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# INSTRUCTIONS FOR COMPLETING THE ADJUSTED COMMUNITY RATE PRICING FORM FOR CONTRACT YEAR 2003

# Contents

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## Introduction

Each Medicare+Choice (M+C) organization must compute a separate adjusted community rate (ACR) for each M+C coordinated care, private fee-for-service, or religious fraternal benefit plan it offers to Medicare beneficiaries. The ACR computations must be made and submitted to the Centers for Medicare and Medicaid Services (CMS) on its ACR forms. An M+C organization that offers an M+C plan with a medical savings account (MSA) must submit certain information on ACR forms, but does not need to submit complete ACR calculations.

In addition to the ACR calculations, M+C organizations must give CMS some additional supporting material. All data submitted as part of the ACR process are subject to audit by CMS or any person or organization that CMS designates.

ACR forms for contract year (CY) 2003 have revisions to address problems that surfaced during the CY 2002 Adjusted Community Rate Proposal (ACRP) process, as well as changes required by law and CMS regulations. The revised forms are consistent with the requirements of the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and related CMS rules and regulations.

To compute its ACR for CY 2003, an M+C organization will calculate an initial rate for the contract year and will report collections (on an accrual basis) from non-Medicare enrollees in the base period (i.e., the year beginning 2 years before the contract year). The initial rate represents the average rate (including both premiums and cost sharing) that the M+C organization would charge to all non-Medicare enrollees that it expects to have enrolled in the same type of plan as the M+C plan priced in the ACR for 2003. The electronic version of the ACR worksheets compares the initial rate (and selected components) that an M+C organization projects for 2003 to the base-period charges (and selected components) to M+C organization enrollees to produce 2-year non-Medicare trend factors. At that point, the ACR worksheets apply the trend factors to base-period Medicare costs to produce Medicare costs for the contract year. M+C organizations that did not have non-Medicare enrollees in the base period or do not expect to have them in the contract year should refer to the special instructions in the discussions of ACR individual worksheets. M+C organizations completing ACRs for plans with no Medicare enrollees in the base period also should refer to the special instructions in the discussions of ACR individual worksheets.

An M+C organization may contract with CMS to offer several M+C plans, including coordinated care plans (e.g., health maintenance organizations [HMOs], preferred provider organization [PPO] plans); religious fraternal benefit plans; MSAs; and private fee-for-service (PFFS) plans. Each type of M+C plan would have its own service area. M+C benefit packages offered under

the various M+C plans could have different Additional Benefits, Mandatory Supplemental Benefits, Optional Supplemental Benefits, and pricing structures.

Each M+C plan that an M+C organization offers must contain a specific set of benefits at the same price to every Medicare beneficiary throughout the plan's service area. The M+C plan offered to Medicare beneficiaries must contain all items and benefits covered under original Medicare (except hospice care) and any required Additional Benefits. The M+C organization can offer (if CMS agrees) Mandatory Supplemental Benefits as part of the specific set of benefits. Finally, the M+C organization can augment its plan with supplemental benefits that Medicare beneficiaries can purchase at their option.

M+C organizations may develop other M+C plans with associated Optional Supplemental Benefits to be offered to Medicare beneficiaries. Offer each M+C plan and its associated Optional Supplemental Benefits throughout the service area of the M+C plan. Each such plan may include a different pricing structure, different Additional Benefits, different Mandatory Supplemental Benefits, and/or different Optional Supplemental Benefits.

M+C organizations must use the CMS ACR forms to develop a pricing structure for each M+C plan. Organizations must submit the information in an electronic format using Excel 97. (***NOTE***—If you use a version newer than Excel 97 to complete CMS's electronic ACR worksheets, please save the file as an Excel 97 file before you submit the electronic worksheets to CMS.) In addition, submit a paper copy of your complete ACR containing a signed certification on Worksheet A. The Office of Management and Budget (OMB) has approved the ACR format and has determined that the worksheets are necessary for the government's efficient operation and do not impose an unnecessary paperwork burden on M+C organizations.

An M+C organization must submit these forms by July 1 of each year for each M+C plan offered in the next year. (CMS may change the July 1 due date for operational purposes.)

Each M+C organization must submit a separate ACR proposal for each M+C plan that the organization intends to market in a given service area. Because M+C plans covering Part B-only enrollees are separate from M+C plans serving enrollees eligible for both Part A and Part B of Medicare, organizations must submit separate ACR forms for any M+C plans covering Part B-only Medicare enrollees. An M+C organization will have Part B-only enrollees if it was a Section 1876 contractor on December 31, 1998, and if it had Medicare enrollees who had Medicare coverage only under Part B and who did not terminate their membership before January 1, 1999.

ACR approval will take place during the summer or fall months so that both CMS and M+C organizations can send information to Medicare beneficiaries before the open enrollment period begins (November of each year).

If you have any questions about the content of these worksheets, please e-mail them to CMS via its web site at www.hcfa.gov.

# What's New for the CY 2003 ACR?

The ACR pricing forms have the following changes for CY 2003:

- Worksheet A (Cover Sheet), Part I A now has a line (line 11) to display an amount to be withheld from an M+C organization's monthly payment from CMS to fund a reduction in enrollees' out-of-pocket costs of the Part B monthly premium. CMS will implement the withholding at the request of the M+C organization. (Worksheet E displays the same value.) Worksheet A also has a Part IV that will allow you to update, as necessary, the standard Part B premium CMS estimated for 2003. Part IV triggers internal checks of your entry on line 11 to ensure that it is within M+C program limits.
- Worksheet A, Part I A, line 12 now can compute weighted average Medicare deductible and coinsurance amounts on a county-by-county basis. CMS has not yet approved such county-by-county computations. However, Worksheet A and Worksheet A1 have been modified, in advance, to permit such county-by-county calculations if CMS approves them. For contract year 2003, the Medicare deductible and coinsurance amount for all counties is $101.61 for Part A/B enrollees and $75.14 for Part B-only enrollees, as shown in Enclosure 1 (Final Estimate of the Increase in the National Per Capita Growth Percentages for 2003) of the CMS letter "Announcement of Calendar Year (CY) 2003 Medicare+Choice Payment Rates," dated March 1, 2002.
- Worksheet A1 (Service Area and Estimate of Annual Payment Rate) has some minor changes and a new column (column d) that allows M+C organizations (M+COs) to adjust the contract year 2002 actual monthly payment rate shown in column c of the form.
- The ACR entries on the 2002 version of Worksheets B, C, D, and E (Part II) that are related to Optional Supplemental Benefits will change as follows:
  - Worksheet B (Base-Period Costs and Enrollment): For 2003 organizations should allocate costs of administration, additional revenues, and receipts for COB–Other to each optional supplemental health care component on Worksheet B. For 2002 M+COs entered the total amount of each of these items related to Optional Supplemental Benefits separately on Worksheet B.
  - Worksheet C (Premiums & Cost Sharing) and Worksheet D (Expected Cost and Variation): For 2003 all the displays of costs, cost sharing, and premiums for Optional Supplemental Benefits formerly in Worksheets C and D have been combined in the new Worksheet F (Adjusted Community Rate for Optional Supplemental Benefits).
  - Worksheet E, Part II (Adjusted Community Rate) has been eliminated. For 2003 the computations formerly in Worksheet E, Part II are in the new Worksheet F.
- Worksheet E, Part I has undergone minor changes including the addition of a new line (line 11) to display amounts to fund Part B premium reductions for enrollees. The amount displayed on line 11 will be withheld from the monthly payments by CMS to a Medicare+Choice organization.

The instructions for the ACR pricing forms have the following modifications:

- New information related to the changes to the ACR pricing forms
- Clarification of instructions
- Information on policy changes such as the waivers related to employer-only plans
- Discussion of stabilization fund issues
- Expansion of material related to frequently asked questions about the ACR
- Incorporation into the instruction of material formerly in Appendix A
- Expansion of the Table of Contents to help users locate items of interest
- Modification of the page headers to help users locate items of interest.

# Definitions

The following definitions cover the specialized terminology used in these instructions.

**Actuarial equivalence** refers to a type of CMS-approved waiver of certain rules that might hinder the design of, development of, or the enrollment in M+C plans under M+C contracts with employers and unions. In this type of waiver, CMS would allow M+C organizations to violate the statutory rules on uniformity of premiums by raising co-pays for a plan benefit in exchange for a modification of the plan premium, an increase in the benefit, or both. This type of waiver generally would relate to prescription drug benefits in an employer or union plan.

**Actuarial swapping** refers to a type of CMS-approved waiver of certain rules that might hinder the design of, development of, or the enrollment in M+C plans under M+C contracts with employers and unions. In this type of waiver, CMS would allow M+C organizations to violate the statutory rules on uniformity of benefits by adding benefits preferred by an employer or union in exchange for a benefit of the same actuarial value in an employer or union plan. Actuarial swapping cannot include an exchange of any Medicare-Covered Benefits. In other words, M+C plans offered to the individual market and plans offered to employer or union groups both must include all Medicare-Covered Benefits (except hospice).

**Additional Benefits** include both health care benefits not covered by Medicare and reductions in premiums or cost sharing for Medicare-Covered Benefits. M+C organizations specify Additional Benefits and must offer them to Medicare beneficiaries at no additional premium.

**Additional revenue** is revenue collected—or expected to be collected—from charges for M+C plan benefit packages that exceed costs incurred or to be incurred. Additional revenue includes such things as revenue in excess of expenses directly related to a benefit package, profits, contributions to surplus, risk margins, risk reserves, and any other premium component not reflected in direct medical care or administrative costs.

The **adjusted community rate (ACR)** for a benefit (e.g., an optional supplemental benefit) or group of benefits *usually* is the base-period costs adjusted to take into account the trend since the base period. However, the ACR is an M+C organization's best estimate of the cost of M+C plan that:

- Had no Medicare enrollees, no non-Medicare enrollees, or both in the base period;
- Expect to have no non-Medicare enrollees in the contract year; or
- Experience both of the previous 2 conditions.

***NOTE—***The term "ACR" also refers to the forms on which ACRs are calculated and documented.

**Administration costs** generally are the costs of managing the type of health care plan being priced in an ACR. Examples of administration costs are occupancy, compensation of administrative employees, sales and marketing, and medical management. Include both the actual costs of reinsurance and user fees (e.g., Information Campaign User Fee) in the costs of administration.

The **average payment rate (APR)** is the weighted average amount per member, per month (PMPM) that an M+C organization expects to receive from CMS (without adjustment for such

things as user fees, transactions involving a stabilization fund, etc.) for all Medicare beneficiaries electing the M+C plan being priced in an ACR. It does not include any bonus payments the M+C organization expects to receive due to offering the first M+C plan in a qualified county. Each year, CMS will publish a rate book containing a payment rate for every county in the United States. The APR for an M+C plan will be based on the county payment rates in the M+C plan's service area, adjusted for demographics, risk, and other considerations related to the Medicare beneficiaries electing the plan.

The **base period** is the most recently ended calendar year before your ACR is due.

**The basic benefit package** (or **basic benefits**) includes both Medicare-Covered Benefits (except hospice care) and Additional Benefits.

A **benefit** includes both health care services and health care items that M+C organizations provide to enrollees and for which the organizations incur direct costs.

The **contract year** is the 12-month period following the submission of the ACR to CMS. The contract year will begin on January 1.

**Cost sharing** includes co-payments, coinsurance, deductibles, and any other charge to enrollees on a per-benefit basis, regardless of who collects them. (Premiums are enrollee charges not on a per-benefit basis.)

**Direct medical care** costs represent the cost of providing medical care net of administration costs and additional revenue.

Reduce costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. When reporting Medicare data on ACR worksheets, assign the amounts from reinsurance recoveries as an offset to the costs for related health care components.

In addition, reduce direct medical costs by the amounts that should have been recovered from coordination of benefits efforts. When reporting Medicare data on ACR worksheets, show separately the COB amounts related to medical care provided to Medicare enrollees (except for COB amounts related to Optional Supplemental Benefits, which should be combined with the costs of individual benefits).

In contrast, do *not* reduce direct medical care by the amount of any cost sharing paid by or on behalf of enrollees. Moreover, do *not* reduce direct medical costs reported on an ACR by the amount of cost sharing charged to plan enrollees regardless of who collects the cost sharing.

**Employer-only plans** are M+C plans that M+C organizations can use as the basis for developing employer or union plans. By definition, organizations do not offer employer-only plans to the individual market. (In other words, a plan offered to the individual market is not an employer-only plan.) An employer-only plan must include at least all Medicare-Covered Benefits (except hospice). M+C organizations must submit employer-only plans to CMS for approval.

**Employer or union health plans** are plans that M+C organizations build onto employer-only M+C plans or onto M+C plans offered to the individual market. Employer or union health plans would be offered to:

- An employer's employees, former employees, or combination thereof; or
- A union's members, former members, or combination thereof.

Negotiations between M+C organizations and employers or unions determine the benefits of such plans; however, they must include at least all Medicare-Covered Benefits (except hospice). M+C organizations cannot offer this type of plan to all Medicare eligibles in the plan's service area. M+C organizations do not need to submit these plans to CMS for approval in their entirety. (However, CMS must approve the plan on which an employer or union health plan is built.)

An **excess amount** is the amount created, in a particular ACR proposal, when the average payment rate (APR) is greater than the ACR (less Medicare's deductibles and coinsurance).

**Expected variation** is an increase or decrease in the projected cost or revenue of an M+C plan reflecting factors not captured in the trends used to calculate the trended values. Such factors may include actual or projected changes in such items as benefit structure, utilization, technology, and demographics.

Use Worksheet D and column d of Worksheet F to make those modifications. For example, if CMS adds another benefit to those covered under original Medicare for the period of the ACR, the cost of the new benefit would not be reflected in the base-period costs for a given plan. Accordingly, an M+C organization would adjust the ACR computation to allow it to approximate more closely the cost that would be incurred in the Medicare population during the ACR period. You can make those adjustments on Worksheet D or Worksheet F in any situation where applying the trends from Worksheet A to base-period costs does not produce the contract-year value you expect.

**H-number (or H#)** is an identification number that appears in a contract between CMS and an M+C organization.

**Health care components** are the individual (or groups of) health care benefits or other activities on the lines (rows) of certain ACR worksheets—e.g., Worksheet B.

The **initial rate** is the per-member, per-year rate (including premiums and cost sharing) to be charged to all non-Medicare enrollees that the M+C organization expects to have enrolled in the same type of M+C plan for the period covered by the ACR. (For ease of computation, all ACR entries are reduced to monthly amounts.) Compute the initial rate using one of two methods:

- A community rating system, or
- A weighted average of all premiums and cost sharing to be charged to the public.

M+C organizations offering a type of plan (for example, provider-sponsored organizations) that will not have an enrolled non-Medicare population will not have an initial rate.

**Individual market** refers to the service area of an M+C plan offered to individuals (i.e., not offered to employer or union groups).

**Loss**, for ACR purposes, is the amount by which the ACR (less Medicare's deductibles and coinsurance) exceeds the APR. Because M+C organizations cannot pass losses through to its Medicare enrollees, the losses cannot affect the premium charged to Medicare enrollees. A loss shown on the ACR does not necessarily represent a financial statement loss.

An **M+C organization** is a public or private entity licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations [PSOs] receiving waivers) and certified by CMS as meeting the M+C contract requirements.

An **M+C plan** is health care coverage offered under a policy, contract, or plan by an M+C organization that includes a specific set of benefits offered at a uniform price to all Medicare beneficiaries residing in the M+C plan's service area. The benefits would include all Medicare-Covered Benefits (except hospice care) and Additional Benefits, and can include Mandatory Supplemental Benefits. In addition, the M+C organization can offer Optional Supplemental Benefits to be purchased at the option of the beneficiary. An organization can offer multiple M+C plans within the service area of the M+C plan or M+C organization. Organizations must offer each M+C plan to all members at the same premium and cost-sharing levels approved for the plan.

**M+C plan types** are coordinated care plans (these include health maintenance organization [HMO] plans, HMO plans with a point-of-service [POS] benefit, PSOs, and PPO plans); religious fraternal benefit plans; M+C MSAs; and M+C PFFS plans.

**M+C service area** means a geographic area approved by CMS within which an eligible individual may enroll in a particular M+C plan offered by an M+C organization. For coordinated care plans and network medical savings account plans only, the service area also is the area within which there exists a network of providers that meets the access standards in 42 CFR 422.112. The service area also defines the area where a uniform benefit package is offered. In deciding whether to approve the service area proposed by an M+C organization for an M+C plan, CMS considers the organization's non-Medicare service area for the type of plan in question (if applicable), community practices generally, and whether the boundaries of the service area are discriminatory in effect. In addition, in the case of coordinated care and MSA plans, CMS considers the adequacy of the provider network in the proposed service area.

Under the BBRA, each M+C plan can have a segmented service area. In the case of segmented service areas, all M+C rules regarding service areas, such as the rule on uniformity of premiums, apply to each segment. The BBRA also requires a separate ACR for each service area segment. For purposes of this instruction, whenever the term "service area" is used, it also refers to service area segments.

**Mandatory Supplemental Benefits** are benefits not covered by Medicare that beneficiaries must purchase as a condition of enrollment in a plan. Usually, M+C organizations charge enrollees premiums or cost sharing or both for those benefits. Mandatory Supplemental Benefits can be different for each M+C plan offered by an M+C organization. M+C organizations must ensure that they do not use Mandatory Supplemental Benefits to discourage enrollment by any particular group of Medicare beneficiaries.

A **Medicare enrollee of an M+C plan (M+C plan enrollee)** is a Medicare beneficiary who elects to join or who an M+C organization expects will elect to join an M+C plan.

**Non-Medicare enrollees** are the enrollees that an M+C organization must consider in determining the base-period collections and initial rate for an ACR. Specifically, in determining those values, an M+C organization must consider the actual or projected costs (as appropriate) of the same type of plan (e.g., coordinated care, PFFS, or MSA) and all service areas of the organization for the type of M+C plan you are pricing in an ACR. Non-Medicare enrollees include any commercial enrollees, Medicaid enrollees, or certain Medicare beneficiaries such as those who are enrolled in a cost-contracting arrangement offered by an M+C organization (e.g., a health care prepayment plan [HCPP]). CMS considers those Medicare beneficiaries to be non-Medicare enrollees of the M+C organization.

An M+C organization cannot classify as a non-Medicare enrollee any Medicare beneficiary who has elected to join—or who an M+C organization projects will elect to join—the M+C plan being priced by an ACR proposal. The 2 categories—Medicare enrollees and non-Medicare enrollees—are mutually exclusive.

**Optional Supplemental Benefits** are benefits not covered by Medicare that beneficiaries can choose to buy or to reject. M+C plan enrollees who choose such benefits pay for them directly, usually in the form of premiums or cost sharing or both. M+C organizations can group those benefits for marketing purposes only or offer them individually to enrollees. Optional Supplemental Benefits can be different for each M+C plan. Compute a separate ACR value for each Optional Supplemental Benefit. Include direct medical, administration, and additional revenue in the ACR value of each benefit.

**Premiums**, for purposes of this document, include all other charges to the enrollees paid to the M+C organization or its designee (as distinct from the Part B premium paid to Medicare) that are not on a per-benefit basis. (Per-benefit charges are called "cost sharing.")

A **stabilization fund** is a non-interest-bearing fund that CMS will establish at your request to withhold a portion of your per capita payments. The amounts withheld are available to you for payment in subsequent contract periods to stabilize fluctuations in the availability of Additional Benefits you provide to your Medicare enrollees.

**Statutory benefit categories** are classifications of health care components for purposes of the ACR. They include **Medicare-Covered Benefits** and **Additional Benefits**, which constitute the basic benefits grouping defined in the Balanced Budget Act of 1997. They also include **Mandatory Supplemental Benefits** and **Optional Supplemental Benefits**, which constitute the supplemental benefits group defined in that act.

**Trend** usually includes actual or projected changes in items such as benefit structure, utilization, charges, or demographics. For purposes of the ACR, trend is a 2-year factor, calculated by Part I B of Worksheet A (Cover Sheet), representing the percentage change between certain non-Medicare values for the base period and contract year. The ACR methodology uses trends to adjust base-period costs of Medicare enrollees—where applicable—to produce contract-year trended values for relevant health care components by statutory benefit category. The trended value, with any necessary adjustments (i.e., "expected variations"), is the estimated ACR value of each health care component for the contract year.

Worksheet A computes three trend values, one for each of the following: "Collections from Enrollees/Initial Rate," "Direct Medical Costs," and "Administration."

A **trended value** is the base-year cost of a health care component that has been modified by one of the trends calculated in Part I B of Worksheet A.

# Chapter 1. General Instructions

M+C organizations must submit their annual renewal premium information (premium and M+C plan documentation) by July 1, 2002, covering the contract period January 1, 2003, through December 31, 2003. Generally, CMS will use this same cycle for all subsequent years. However, CMS may adjust the July 1 due date under special circumstances.

Submit one ACR proposal for each M+C plan that an M+C organization intends to market in the service area in its M+C contract. (In addition, if your organization segments a service area, submit a separate ACR for each plan in each segment.) Organizations with both Part A/B Medicare enrollees and remaining Part B-only Medicare enrollees generally must have separate M+C plans for each of those two groups. A Medicare beneficiary with Medicare coverage only under Part B cannot elect an M+C plan after December 31, 1998. However, a Medicare beneficiary (with Part B coverage under Medicare) who was a Medicare enrollee of a Section 1876 contractor on December 31, 1998, shall be considered to be enrolled with that organization on January 1, 1999, if the organization had an M+C contract for providing benefits on the latter date. Health benefit coverage that M+C organizations provide to such remaining Part B-only enrollees constitutes a separate M+C plan (which requires a separate ACR proposal).

***NOTE***—CMS encourages M+C organizations to submit as few plans as possible for its Part B-only members, rather than duplicating each of its A/B plans for them. In fact, an M+C organization can submit one plan for all its Part B-only members under an M+C contract if they are in the same type of plan. In addition, if you offer your Part B-only members the same benefits as A/B members for the same price that A/B members are charged, then you are not required to submit a separate ACR for the Part B-only members.

In order for CMS to approve an ACR proposal in a timely manner, the proposal must be filed as early as possible, must be in a format acceptable to CMS, and must contain backup data to support certain figures and computations. If you do not have enough enrollment experience to develop data, you may use financial budgeting techniques that are generally acceptable throughout the health care industry.

CMS reviews all ACR proposals. CMS reviewers might request additional information about or clarification of submitted data. In some instances, CMS reviewers might have to ask for certain information before completing their full review of an ACR. M+C organizations need to respond promptly to requests from CMS. The approval of an ACR proposal is delayed each time CMS has to request additional documentation. To avoid unnecessary delays and speed up the review process, follow the guidelines listed below (and any supplemental guidelines that CMS issues) when preparing your ACR proposal.

Please observe the following guidelines to ensure timely review of your ACR:

- Show clearly in the ACR proposal per member, per month (PMPM) values for all cost sharing listed in the plan benefit package (PBP) for the M+C plan.
- Remember that a plan can have only one premium, one cost-sharing structure, one set of Additional Benefits and one set of Mandatory Supplemental Benefits. You can vary those elements as long as you create a separate plan with its own ACRP for each distinct group of variations.

- Don't create high-option plans, e.g., plans that are identical except for different Optional Supplemental Benefits. Instead, offer one plan with different Optional Supplemental Benefits.
- Include recoveries from reinsurance contracts in direct medical costs. When reporting Medicare data, assign the amounts from reinsurance recoveries as an offset to the costs of related health care components (direct medical expense).
- Include both the actual costs of reinsurance and user fees (e.g., information campaign user fee) in the costs of administration.
- Use medical benefit categories (health care components) set forth on the lines of certain ACR worksheets. The Administration and Additional Revenue components must contain plan data when you submit your ACR.

  With respect to Worksheet B (base-period costs) only, you may group data for health care components—other than Point-of-Service (POS), Administration, and Additional Revenue—that your accounting system will not break out. If you must group the data for different health care components, explain which benefits you grouped and obtain CMS's concurrence on the category groupings.

  Do not group data required for health care components on Worksheets C, D, and F.

  Do not group data required for the statutory benefit categories (columns) on Worksheets B, C, and D.
- Organize all backup data by worksheet. Additional, detailed instructions for sending the ACR and supporting material to CMS will be available separately. Check those additional instructions for changes in the July 1 due date for ACRPs.
- Group medical benefits included in specific categories consistently from year to year.
- Display your identification number (i.e., your Medicare+Choice contract number) clearly in the cover letter and in all subsequent correspondence with CMS.

## *Accounting Considerations*

Except as provided in the next paragraph, M+C organizations must have an adequate accounting system that is accrual-based and must use generally accepted accounting principles (GAAP) to develop ACRs.

For organizations that are part of a government entity using a cash basis of accounting, ACR cost data developed on that basis is acceptable. However, only depreciation on capital assets, rather than the expenditure for the assets, is acceptable for ACR costing purposes.

## *Relationship of the ACR Pricing Form to the Plan Benefit Package Form*

M+C organizations must submit a PBP with each ACR. The two documents together constitute an ACRP for an M+C plan. Unlike the ACR, the PBP (except for its certification form) exists

only as an electronic document—there is no paper version of it. Instructions for completing the PBP worksheet are available from CMS separately.

The ACR pricing form uses 21 direct medical health care components (exclusive of costs of administration and additional revenue) on the lines of Worksheets B, C, and D. Entries for those components must be consistent with related entries on the PBP for the same plan.

> ***EXCEPTION***—Entries on Worksheet B that do not relate to Optional Supplemental Benefits do not have to be consistent with the PBP categories if the organization has received approval from CMS to group data for individual health care components on that worksheet.

Relating the data in the two documents is relatively easy, because the PBP groupings of individual health care benefits have the same names as the health care components of the ACR. For example, if your plan includes any of the preventive benefits that are shown under the PBP category called "Preventive Services" (category 14), you would include the costs for those benefits on the Preventive Services line of your ACR.

## *ACR Electronic Worksheets and Database*

CMS will provide ACR forms to you in Excel format. Send both paper copies and electronic copies of the ACR forms, with all required backup material, to CMS by the due date. Electronic copies of each ACR worksheet are accessible through CMS's Health Plan Management System (HPMS). CMS will provide separate detailed instructions pertaining to

- access to HPMS and related matters and
- submission of paper copies of the ACR and related backup material.

The following sections explain how to fill out each individual worksheet in the ACR proposal. In addition to the instructions in this document, most electronic worksheets contain pop-up notes in many of the cells that provide limited on-line instructions for specific cells or groups of cells. Use the pushpin symbols at the worksheet's upper left corner to activate or deactivate the pop-up notes. Normally, the notes are activated. When the notes are activated, move your cursor to a red triangle to view the notes for that cell.

Please note that you must make certain entries described in subsequent chapters. When you submit (upload) your ACR to CMS via HPMS, the system will check for some of the required entries and will not permit an upload if any of that information is missing. To reduce the number of failed uploads, pre-upload validation software will be available for you to use before you submit your ACR. The validation software, which is separate from the ACR worksheets, will allow you to spot ACR errors such as missing required data. If you correct all the errors flagged by the validation software, your ACR workbook should be ready for a successful upload to HPMS. You must use the validation software for all of your HPMS uploads.

In addition, the electronic worksheets have built-in validation features that will prompt you to add or delete entries as appropriate. For example, cells highlighted in yellow signify a missing entry in that cell or in a linked cell. On the other hand, cells highlighted in red signify an unnecessary entry, perhaps one that belongs in another cell. In other examples, the worksheets will not allow negative entries or text entries where they are inappropriate.

The purpose of the validation features is to reduce common errors by users, thereby reducing the number and complexity of resubmissions of ACRs. Reduced complexity and fewer resubmissions reduce M+C organizations' workload and simplify the CMS review of ACRPs. CMS has noticed that, in the past, some organizations have defeated the ACR workbook validation features by copying ACR entries from personal spreadsheets or by linking personal spreadsheets to an ACR workbook, Please refrain from such copying and linking in order to facilitate the verification features built into the ACR worksheets.

## *Employer-Sponsored and Union-Sponsored Enrollees in Service Area*

When filing ACRs for M+C plans offered to individuals, an M+C organization should include on Worksheet B, in addition to the costs of individual plan members, the costs of employer-sponsored or union-sponsored members or both who reside in the service area of the individual plan.

In addition, the APR for the M+C plan must include projected employer-sponsored or union-sponsored enrollees or both who live in the plan service area.

# Chapter 2. Worksheet A—Cover Sheet

The Cover Sheet allows you to enter specific plan data that is used in other worksheets. In addition, it summarizes the results of calculations from other worksheets. Finally, it contains a certification statement.

## *Part I A—Organization and Plan Data*

The following paragraphs provide line-by-line instructions for Part I A of the worksheet.

### General Information

**Line 1—Name of M+C Plan.** On line 1, enter the name of the M+C plan you are offering to Medicare enrollees. You must provide the name of the plan.

**Line 2—Org. # (Organization Number).** On line 2, enter the alphanumeric designation for the contract unique to this ACR proposal. The designation should begin with a capital P and include five Arabic numerals. Enter this number in the form of P#####. Please include leading zeros. For example, to enter P00122, include all five numbers. Obtain the Org. # number from your contract with CMS. You must enter it on line 2. Please do not enter the H-number (H#) here.

**Line 3—H#.** Enter the H-number for the plan on line 3. The designation should begin with a capital H and should include four Arabic numerals. Enter this number in the form of H####. Please include all leading zeros. Obtain this number from your contract. You must enter the H-number (H#) on line 3.

**Line 4—Plan ID.** The plan ID is a designation, which with a corresponding H# forms a unique identifier for the plan being priced in this ACR. Plan IDs contain three Arabic numerals. Except as indicated below, all plans under each H# are to be numbered consecutively in your initial upload, starting with 001. You must enter a plan ID on Worksheet A. Enter the same plan ID on line 4 that was used for the corresponding PBP. Please remember to enter all leading zeros. For example, enter 001 for plan number one.

CMS will assign plan ID numbers according to the following rules. If your organization is offering the same plan in CY 2003 as it did in CY 2002, CMS will use the plan ID CMS assigned to the plan in CY 2002. In this context, the term "same plan" refers to a plan that, for both CY 2002 and CY 2003,

- is of the same type (e.g., HMO);
- is offered to the same type of enrollee (e.g., Part B-only);
- covers substantially the same service area (i.e., has at least one common county); and
- has the same or different benefits, premiums, and cost sharing.

> ***EXCEPTION*—**M+C organizations preparing ACRs for employer-only plans (see Chapter 14) should use plan IDs starting with 801 for the first plan under a given contract, 802 for the second plan, etc.

> ***REMINDER***—If your CY 2003 contract reduces the previous year's service area (e.g., deletes an entire county of a plan) or changes the service area of a plan so that at least one payment area (e.g., county, parish) is reduced, call your plan manager to discuss the effects of the change on plan enrollees.

**Line 5—Type of Plan.** Enter the type of M+C plan, such as coordinated care plan, religious fraternal benefit plan, M+C MSA, or PFFS. You must provide that information.

> ***REMINDER***—A separate ACR proposal must be submitted for each M+C plan.

When completing this cell, select one of the following codes from the drop-down menu on the electronic worksheet:

- Coordinated care plans:

| | |
|---|---|
| Health maintenance organizations | HMO |
| Health maintenance organizations with a point-of-service (POS) option | HMOPOS |
| Provider-sponsored organizations | PSO |
| Preferred provider organizations | PPO |
| Other | CCOTH |

- Religious fraternal benefit plans — RFB
- M+C private fee-for-service plans — PFFS
- M+C MSA plans — MSA
- Other types — OTH

> ***EXCEPTION***—If you are using the ACR forms for a non-M+C plan such as a cost HMO, select "Non-M+C" from the drop-down menu

**Line 6—Enrollee Type.** If an ACR prices any type of plan covering enrollees eligible for both Part A and Part B of Medicare, choose "Part A/B" from the drop-down menu for this cell. If an ACR prices an HMO or HMOPOS type of plan covering enrollees eligible only for Part B, choose "Part B-only" from the drop-down menu.

> ***REMINDER***—While nearly all M+C enrollees are eligible for both Part A and Part B of Medicare, some are eligible only for Part B benefits. CMS regards plans serving Part B-only enrollees as separate from plans serving Part A/B enrollees. Generally, ACRs that price plans serving Part B-only enrollees must be separate from ACRs that price plans serving Part A/B enrollees. However, if you offer your Part B-only members the same benefits as A/B members for the same price that A/B members are charged, then you are not required to submit a separate ACR for the Part B-only members.

**Line 7—ACR Contract Year.** This cell is preloaded with the calendar year that contains the ending date for this ACR. The cell is locked. The period covered by an ACR must include at least 12 months and start on the first day of the calendar year (e.g., January 1, 2003) and end on the last day of the calendar year.

**Line 8—Average Payment Rate ($PMPM).** On line 8, the worksheet enters the APR from Worksheet A1. The cell is linked to Worksheet A1 and therefore is locked. The APR is the amount an M+C organization estimates that CMS will pay (except for certain withheld amounts such as the information campaign user fee) in dollars and cents PMPM during the period covered by the ACR for each Medicare beneficiary electing the M+C plan you are pricing in the ACR.

**Line 9—Contribution/Withdrawal-Stabilization Fund ($PMPM).** Enter on line 9 the amount of contributions to or withdrawals from your stabilization fund in dollars and cents (two decimal places) per member, per month.

Contributions are the amount your M+C organization elects to deposit in a stabilization fund. Please enter contributions as a positive number. A contribution on line 9 cannot exceed 15 percent of the plan excess shown on line 8 of Worksheet E without prior CMS approval. CMS regulations also state that a contribution for the contract period cannot cause the total value of the plan's stabilization fund to exceed 25 percent of the excess amount applicable to the M+C plan for the contract period. If the contribution you enter does not meet the 15 percent test described above, the system will generate an error message on line 9 of Worksheet E.

If your organization has previously established a balance in a stabilization fund and wants to withdraw an amount to stabilize benefits in the contract period of the ACR, enter a negative number.

The entry of a number other than zero in this cell will directly effect CMS's payment to you. In other words, CMS will change the monthly amount it will pay to the organization per Medicare enrollee by the amount on line 9.

See Chapter 16 for more information on stabilization funds.

**Line 10—Number of Years to Hold Stabilization Fund.** Enter the number of years, after the end of the period covered by the ACR, for which you want CMS to hold the amount you contribute to a stabilization fund. Amounts not withdrawn by the end of this period will be returned to Medicare. Please do not enter a value in this cell if your organization is not contributing to a stabilization fund during the contract year.

**Line 11—Reduction of Part B Premium ($PMPM).** If your plan has a benefit providing for a reduction of Part B premiums for the plan enrollees, enter the amount in dollars and cents PMPM

that you elect to have withheld from your monthly M+C payment for the contract period to fund the benefit.

BIPA permits Medicare+Choice organizations to offer reduced Medicare Part B premiums to their enrollees as an additional benefit. The mechanism to fund this reduction is for an M+C organization to elect a reduction in its Medicare+Choice payment of up to 125 percent of the annual Part B premium. CMS will apply 80 percent of this amount to reduce the Part B premium of plan enrollees; the remaining 20 percent will be savings to the M+C program.

The amount on line 11 also is limited by the amount of the adjusted excess on Worksheet E, Line 10. Therefore, do not enter an amount on line 11 exceeding the smaller of the adjusted excess or 125 percent of the standard Part B premium ($56.90 per month expected for 2003).

For example, assume that the Part B premium is $56.90 per month and an M+C organization elects to have the full 125 percent of the Part B premium amount ($71.13 PMPM) withheld from its payment for each enrollee. Assume, too, that the adjusted excess amount on Worksheet E is $71.13 PMPM or more. Therefore, CMS would withhold the full $71.13 PMPM from its monthly payment to the M+C organization. In this example, CMS would apply 80 percent of $71.13 ($56.90 PMPM) to reducing the Part B monthly premium that plan enrollees would have to pay directly to the Federal government.

As with other Additional Benefits, M+C organizations will have to apply reductions in the Part B premium uniformly to all plan enrollees.

**Line 12—Medicare Deductibles and Coinsurance ($PMPM).** The worksheet computes the value for line 12 in dollars and cents PMPM. Worksheet A uses the Medicare deductible and coinsurance values along with the projected plan membership (both from Part IV of Worksheet A1) to compute a weighted average Medicare deductible and coinsurance amount for the plan. CMS's Office of the Actuary computes the actuarial values of original Medicare's deductible and coinsurance amounts in dollars and cents per member, per month. Those actuarial values are preloaded into the Worksheet A1. The amount on line 12 will be the correct amount for the enrollee type you choose for line 6 above. Line 12 also includes the actuarial value of Original Medicare's psychiatric co-payment amount as provided by CMS's Office of the Actuary.

You do not have to make an entry on this line. The cell is locked.

## Enrollment Information

**Line 13—Medicare Enrollment Capacity.** Enter Medicare enrollment capacity, which is the M+C organization's capacity allocated to Medicare beneficiaries during the contract period. Specifically, it is the total number of Medicare enrollees to which the M+C organization estimates it could reasonably provide the quantity and quality of benefits (with sufficient access) offered by the M+C plan during the period covered by the ACR. Enter a value on this line unless your organization has no capacity limit. When entering a value, please enter a whole number. Enter "unlimited" on line 13 if you have no Medicare enrollment capacity limit.

**Line 14—Non-Medicare Enrollment Capacity.** Enter the capacity allocated to non-Medicare enrollees during the contract period. This is the total number of non-Medicare enrollees to which the M+C organization estimates it could reasonably provide the quantity and quality of benefits (with sufficient access) offered by the same type of plan being priced in an ACR for the period covered by the ACR. Enter a value on this line unless your organization has no capacity limit.

When entering a value, please enter a whole number. Enter "unlimited" on line 14 if you have no non-Medicare enrollment capacity limit.

**Line 15—Projected Average Monthly Medicare Membership.** This cell is linked to Part II of Worksheet A1. No entry is necessary. The cell is locked.

**Line 16—Projected Avg. Monthly Non-Medicare Membership.** Enter the average number of non-Medicare members (on a monthly basis for the entire contract period) expected to be enrolled in all benefit packages offered by your organization through the type of M+C plan being priced in this ACR. Please enter a whole number.

**Line 17—Delegation of Authority to Submit Certain Changes.** Complete a certification (at the bottom of Worksheet A) for each ACR as discussed in the section (below) on Certification Signatures. If an organization changes its ACR after the initial submission to CMS, the certification must be re-signed, re-dated, and submitted with the changed ACR unless you select "yes" from the drop-down menu for line 17. In that case, the contact person named on line 6 of Part I B will be authorized to submit to CMS the types of changes described below without submitting a new, completed certification with the revised ACR:

- On Worksheet A—

  Part I A, lines 13, 14, and 16

  Part I B lines 5, 7, and 8.

- On Worksheets A1, B, B1, C, C1, D, and F
- Any unlocked cell, as long as the change does not affect Worksheet A of the most recent CMS-approved ACR for your plan.

## *Part I B—Organization and Plan Data*

The first four lines of Part I B provide 2-year trend calculations used in other ACR worksheets. For example, Worksheets D and Worksheet F both import trend data from this worksheet in order to calculate trended values for 2003. Worksheet D and Worksheet F multiply the trends and Worksheet B (base-period) data to obtain the trended values.

When completing this worksheet or Worksheet B, enter the data you have. Generally, you should not omit one type of requested data because you don't have another type of data. For example, if you have non-Medicare data for the base period and for the initial rate but don't have any Medicare enrollees in the base period, the ACR forms will compute a trend but will have no base-period data with which to compute trended values for 2003. In that case, you should complete Worksheet B and enter your 2003 data on Worksheet D or F as appropriate. The following table tells you how to handle different situations of this general type.

| Case | Problem | | | Solution | | | |
|---|---|---|---|---|---|---|---|
| | All Plans of Same Type of Plan in ACR | | Plan in ACR | Worksheet A Part I B Non-Medicare Costs | | | |
| | Non-Medicare Enrollees in Base Period (2001) | Non-Medicare Enrollees in Contract Period (2003) | Medicare Enrollees in Base Period (2001) | Base Period (2001) | Initial Rate (2003) | Worksheet B (Medicare Costs) | Expected Variations (Worksheet D and Worksheet F) |
| a | b | c | d | e | f | g | h |
| 1 | Some | Some | Some | Fill In | Fill In | Fill In | Optional |
| 2 | None | None | None | Blank | Blank | Blank | Use for 2003 costs |
| 3 | Some | None | None | Fill In | Blank | Blank | Use for 2003 costs |
| 4 | Some | Some | None | Fill In | Fill In | Blank | Use for 2003 costs |
| 5 | None | Some | Some | Blank | Fill In | Fill In | Use for 2003 costs |
| 6 | None | None | Some | Blank | Blank | Fill In | Use for 2003 costs |
| 7 | Some | None | Some | Fill In | Blank | Fill In | Use for 2003 costs |
| 8 | None | Some | None | Blank | Fill In | Blank | Use for 2003 costs |

The following paragraphs provide line-by-line instructions for Part I B of the worksheet

## Non-Medicare Information: Column a—Base Period

Part I B, lines 1 through 3, of the worksheet will accept positive entries ($PMPM) with many decimal places. If you enter data on any one of lines 1, 2, or 3, you must enter data on all three lines.

**Line 1—Collections from Enrollees.** M+C organizations that had non-Medicare members in the base period must enter on line 1 their base-period collections from non-Medicare enrollees in dollars and cents per member, per month on an accrual basis. If your organization did not have non-Medicare members in the base period, leave line 1 (and lines 2 and 3) of column a blank.

Base-period collections are the average amount per member, per month collected (premiums and cost sharing) in the base period from all non-Medicare enrollees for all benefit packages offered by an M+C organization under the type of M+C plan being priced in an ACR. Report collections from enrollees under generally accepted accounting principles. The collections from enrollees should include all cost sharing charged to non-Medicare enrollees under the specific type of plan, regardless of who collected it. The collections from enrollees contain three components that represent

- direct medical care costs;
- administration costs; and
- revenue (called "additional revenue") received in excess of the costs actually incurred in delivering the benefits contained in all of your non-Medicare benefits packages offered under this type of M+C plan.

**Line 2—Direct Medical Care.** Enter on line 2 direct medical care in dollars and cents per member, per month. Direct medical care represents the cost of providing medical care net of administration and additional revenue. Reduce costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. In addition, reduce direct medical costs by the amounts recovered from coordination of benefits efforts. In contrast, do *not*

reduce direct medical care by the amount of any cost sharing paid by or on behalf of Medicare enrollees.

**Line 3—Administration.** Enter on line 3 administration costs in dollars and cents per member, per month. The entry represents the costs of administration of the type of M+C plan being priced. Examples of administration costs are occupancy, compensation of administrative employees, sales and marketing, medical management, and other expenses. Include both the actual costs of reinsurance and user fees (e.g., Information Campaign User Fee) in the costs of administration. Include only those administration costs that bear a significant relationship to the type of plan you are pricing in an ACR.

**Line 4—Additional Revenue.** The worksheet calculates additional revenue in dollars and cents PMPM automatically. Line 4 contains the result of subtracting the sum of line 2 and line 3 from line 1. The worksheet will permit negative values for additional revenue. Additional revenue represents the revenue properly accrued beyond the costs actually incurred. The cell is locked.

## Non-Medicare Information: Column b—Contract Period

Part I B, lines 1 through 3, of the worksheet will accept positive entries ($PMPM) with many decimal places. If you enter data on any one of lines 1, 2, or 3, you must enter data on all three lines.

**Line 1—Initial Rate.** M+C organizations that expect to have non-Medicare members in the contract year must enter the initial rate for that period on line 1 in dollars and cents per member, per month. Otherwise, leave line 1 (and lines 2 and 3) of column b blank.

The initial rate is an amount your organization calculates using a community rating system or a weighted average of premiums and cost sharing method. It represents the average amount per member, per month expected to be collected (premiums and cost sharing) from all non-Medicare enrollees for all benefit packages offered by an M+C organization under the same type of plan as one priced in your ACR during the period covered by the ACRP. The initial rate should include all cost sharing to be charged to non-Medicare enrollees.

The initial rate contains three components that represent expected

- direct medical care costs;
- administration costs; and
- revenue (called “additional revenue”) to be received in excess of the costs actually incurred in delivering the benefits contained in all of your non-Medicare benefits packages offered under this type of M+C plan.

Go to the end of this chapter for detailed instructions on computing the initial rate.

**Line 2—Direct Medical Care.** Enter on line 2 direct medical care in dollars and cents per member, per month. Direct medical care represents the cost of providing medical care net of administration and additional revenue. Reduce costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. In addition, reduce direct medical costs by the amounts recovered from coordination of benefits efforts. In contrast, do *not* reduce direct medical care by the amount of any cost sharing paid by or on behalf of Medicare enrollees.

**Line 3—Administration.** Enter on line 3 administration costs in dollars and cents per member, per month. The entry represents the expected costs of administration of the type of M+C plan you are pricing in an ACR. Examples of administration costs are occupancy, compensation of administrative employees, sales and marketing, medical management, and other expenses. Include the actual cost of reinsurance and user fees (e.g., Information Campaign User Fee) in the costs of administration. Include only those administration costs that bear a significant relationship to the type of plan you are pricing in an ACR.

**Line 4—Additional Revenue.** The worksheet calculates additional revenue in dollars and cents PMPM automatically. The cell contains the result of subtracting the sum of line 2 and line 3 from line 1. The worksheet will permit negative values for additional revenue. The entry represents the expected revenue properly accrued beyond the expected costs. The cell is locked.

## Non-Medicare Information: Column c—Two-Year Trend

**Line 1 through Line 4—Trend Calculation.** The worksheet automatically calculates a trend value on lines 1 through 3 of column c. The trend is the 2-year change between the base period and the contract year. In other words, the trend values are not annualized. The ACR forms apply trend values to relevant base year costs using formulas in Worksheet D and Worksheet F to calculate trended values for individual health care components.

If there are any blank entries on line 1, 2, or 3 of column a or column b, "No trend" will appear in lines 1 through 3 of column c. In that case, the worksheet does not compute any trended values. Instead, you must enter your best estimates of the costs of individual health care components in the appropriate expected variation cells of Worksheet D and Worksheet F.

The worksheet does not calculate a trend for line 4 (Additional Revenue). As described above, additional revenues are not projected separately, as are other health care components. Instead, the ACR forms calculate contract-year values for additional revenues as residuals on Worksheet D.

The cells for lines 1 through 4 in column c are locked.

***NOTE***—If the loss ratio (direct medical costs divided by total revenue requirements) decreases between the base period and the contract year, CMS may ask you to document the reasons for the decrease.

## Organization Name and Plan Contact

Lines 5 through 8 in Part I B of the worksheet will accept text entries.

**Line 5—Name of M+C Organization.** Enter the name of the M+C organization submitting the plan priced in the ACR.

**Line 6—Plan Contact Person's Name and Position.** Enter the name and position title of the person whom CMS should contact for answers to questions about your ACR.

**Line 7—Plan Contact Person's Telephone Number and Area Code.** Please enter the telephone number (with the area code) of the person listed on line 6. Enter all 10 digits consecutively without parentheses or dashes.

**Line 8—Plan Contact Person's E-mail Address.** Please enter the e-mail address of the person listed on line 6. If the person has no e-mail service, enter "None."

## *Part II—M+C MSA Supplemental Data*

M+C organizations offering an M+C MSA plan are not required to complete all ACR worksheets to price that type of M+C plan. However, such organizations must furnish certain information about MSAs on ACR worksheets. In addition to describing the benefits contained in the plan as reported on the PBP form, you must furnish information requested for this worksheet in Part I A (lines 1 through 6, 12 through 16), Part I B (lines 5 through 8), Part II, and the certification. MSAs also must submit Worksheet A1 and a PBP. Non-network MSA plans should contact the plan manager assigned by CMS for further directions.

The following paragraphs provide line-by-line instructions for Part II of the worksheet. All line numbers refer to column a.

**Line 1.** Enter the annual deductible in dollars and cents per member for the M+C MSA plan. Obtain the maximum allowable deductible amount from CMS's Office of the Actuary.

**Line 2.** Enter the M+C MSA monthly premium per member in dollars and cents. If this amount is less than the monthly county capitation rate, the difference is the monthly amount that CMS will deposit in the M+C MSA plan enrollee's MSA account. CMS will deduct the difference for each M+C plan enrollee from your monthly payment. The amount deposited in the enrollee's account will equal the monthly difference times the number of months during the contract year for which the Medicare beneficiary has elected the plan. CMS will deposit the full amount in the enrollee's MSA account at the time of the initial election.

**Line 3.** Enter the M+C MSA monthly supplemental premium per member (if any) in dollars and cents.

**Line 4.** Enter the actuarial value of any cost sharing per member, per month on supplemental benefits, if offered, in dollars and cents.

**Line 5.** Enter (in dollars and cents) the monthly average of amounts collected per member in the most recent calendar year from M+C plan enrollees electing this M+C plan.

## *Part III—Summary of M+C Enrollee Charges from Worksheet C*

Part III is a summary of M+C enrollee charges. The worksheet imports the data from Worksheet C. No entries are required. The cells are locked.

Note that the total premium for Optional Supplemental Benefits is merely the sum of the individual premiums for each package of those benefits—it does not represent a "high option" for the plan. In addition, the total premium is mainly for purposes of the certification described in this chapter. The total premium might not be meaningful for other uses if two or more of the packages of Optional Supplemental Benefits overlap each other.

If "MSA" appears on line 5 of Part I A, then "MSA" will appear in all cells of Part III.

## *Part IV—Medicare Part B Premium*

The worksheet has a preloaded value of $56.90 PMPM on line 1. People who are eligible for benefits from Part B of Medicare must pay a premium to the Federal government even though they join the M+C program. When CMS published these instructions, that premium was $56.90 PMPM.

If your M+C plan is going to offer a benefit in 2003 that will pay all or part of your plan enrollees' Medicare Part B premium, please check with CMS to make sure it has not announced a new premium for 2003 since it published these instructions. If CMS has announced a new premium, enter the PMPM amount of the new premium on line 1.

Entering the new premium automatically will adjust limits built into the worksheets that will keep you from entering too large a number on Worksheet A, Part IA, line 11. Line 11 represents the amount to fund the benefit that pays Part B premiums and that CMS will withhold from its monthly payment to your organization.

If your plan is not going to offer such a benefit in 2003, ignore Part IV of Worksheet A.

## *Certification Signatures*

The chief executive officer, the chief financial officer, and the person in charge of marketing must all sign and date the certification at the bottom of Worksheet A.

In general, certification signatures are required for the initial ACR and any modified ACRs submitted after the initial one. However, you may omit certification signatures when you modify ACRs under certain circumstances. See the instructions for line 16 of Part I A.

Please type the name of each official in the box above the corresponding position title.

## *Detailed Instructions for Calculating the Initial Rate*

The initial rate is the rate in dollars per-member, per-year to be charged to all non-Medicare enrollees that your M+C organization expects to have enrolled for the same time and in the same type of M+C plan covered by the ACR you are preparing. The initial rate includes both premiums and cost sharing. For ease of computation, all ACR entries are reduced to amounts per member, per month.

The initial rate represents an average of financial data for your non-Medicare enrollees. Therefore, the actual premium rates and cost-sharing amounts you intend to charge your non-Medicare enrollees may vary from the initial rate due to differences in such things as benefit packages, family composition, and enrollment periods.

Generally, you construct an initial rate by starting with your organization's total budgeted revenue and expenses of a specific M+C plan type for non-Medicare enrollees during the contract period. Next, convert those figures into PMPM rates representing projected revenue requirements in total and for direct medical care and administration. The initial rate includes all charges (even optional riders) to non-Medicare enrollees whether collected directly by the organization or by its provider network. However, you would remove the value of benefits that

are a result of private negotiations in the context of the M+C program (e.g., with employer groups) and certain Medicaid benefits (see 42 CFR 422.106 for further explanation).

## Calculating an Initial Rate

Your ACRP can use an initial rate calculated by either:

- A community rating process; or
- The weighted average of all premiums and cost sharing charged to non-Medicare enrollees.

However, if you use the community rating methodology and charge premiums to your non-Medicare population, you must compute a total premium under the weighted average of premiums and cost sharing methodology. If the total premium from a weighted average of premiums and cost sharing is less than the initial rate calculated under the community rating methodology, then you must provide adequate supporting documentation for the difference.

### *Community Rating Method*

Community rating is a method of establishing premiums for health insurance based on the average cost of actual or anticipated health care used by all subscribers. A community rate does not vary for different groups or subgroups of subscribers. Medicare requires you to establish rates on a per-person basis, because eligibility in Medicare is individually determined and Medicare payments to organizations are based on individual enrollment. Accordingly, the PMPM rates must be uniform for all groups, excluding Medicare enrollees, and must reflect the revenue requirements (future budget) of your organization (exclusive of revenues needed to pay for Medicare enrollees) divided by the total number of non-Medicare member months for the budget year. Below is a formula that shows how the community rating process works:

1. Calculate the total actual budget for your organization by type of plan. Deduct expenses and items attributable to Medicare+Choice enrollees of that type of plan. The budget should include any rate changes pending with the State insurance commission or OPM that reflect adjustments to premiums and adjustments for expected inflation.
2. Adjust the total actual budget by removing anticipated revenue from certain coordinated benefits (e.g., Workers' Compensation) and by making other adjustments described in the section on initial rate adjustments.
3. Divide the (adjusted) projected budget by the total number of member months (excluding Medicare enrollment) projected for enrollment during the contract period.

### *Weighted Average of All Premiums and Cost Sharing*

An alternative to the community rating system for calculating the initial rate is to calculate the weighted average of all premiums and cost sharing to be charged to the public. This methodology requires you to add the premiums and cost sharing to be charged to each individual non-Medicare enrollee using each of the premiums and cost sharing amounts you use for non-Medicare enrollees. Next, divide the sum by the total number of the member months of the plans in which premiums are charged. Make adjustments, as needed, of the types described in the next section. The resulting total average premium is the total initial rate premium to be used in the ACR computation. The premium developed from the weighted average of premiums and cost sharing can include allowances for expected inflation.

## *Adjustments to Data for Initial Rate*

Below is a summary of the types of adjustments that you must make to the data used for your initial rate. The adjustments apply to calculations under either the adjusted community rate or weighted average methodologies.

1. Deduct revenue expected from non-enrollees and from sources unrelated to revenue collected for medical care. Show your total revenue requirements, on a PMPM basis, for providing medical benefits to non-Medicare enrollees. Be sure to eliminate all revenue required to service Medicare members.
2. Subtract any revenue you may have included to make up losses experienced by your organization under M+C contracts before the one covering the ACR on which you are working. CMS regulations at 42 CFR 422.310(b)(5) specifically bar you from including such losses in your initial rate.
3. Remove anticipated revenue from certain coordinated benefits for non-Medicare enrollees. For example, remove anticipated revenue from health insurance payers for Medicare-Covered Benefits where Medicare is not the primary payer, as described in section 1862(b) of the Social Security Act, including the following:
   - Workers' compensation;
   - Automobile or liability insurance; and
   - No-fault insurance.
4. Identify the portions of the total initial rate related to direct medical care and administration. The residual amount should reflect additional revenue.

Provide worksheets with your ACRP to support your initial rate calculations.

# Chapter 3. Worksheet A1—Service Area and Estimate of Annual Payment Rate

Worksheet A1 has three purposes: to identify the service area of the M+C plan priced in this ACR, to calculate the plan's APR, and to display the data for calculating the Medicare deductible and coinsurance on Worksheet A. Please complete Worksheet A1 for all plan types, including MSAs.

The APR calculation in this worksheet is intended to simplify the ACR process. Most cells requiring data collected or produced automatically by CMS show the correct values corresponding to the State-county codes you entered in column a. If your organization can accept the resulting APR calculation without any plan-level adjustments in column l, then you will not have to submit any material with your ACR to substantiate them. If your organization needs to make plan-level adjustments in column l, please submit supporting material with your ACR to substantiate the adjustments.

The worksheet calculates the plan's CY 2003 APR by first calculating an APR for each county in the service area. Plan-level adjustments, if any, affect individual county APRs. Next, the worksheet calculates the plan APR per member, per month (PMPM) as an average of total payments for all counties, weighted by plan membership.

The formulas for the calculations are as follows:

**APR by County:**

$$\left(\frac{AMP2002_{Cn}}{CMP2002_{Cn}} \times CMP2003_{Cn} \times \left[1 + \left(\left(\frac{RF2003 - RF2002}{RF2002}\right) \times 0.1\right)\right]\right) - PLA = CAPR2003_{Cn}$$

Where:

- AMP2002 is the CY 2002 actual monthly payment for a county in the plan ($PMPM).
- CMP2002 is CMS's CY 2002 county payment rate for a county in the plan ($PMPM).
- CMP2003 is CMS's CY 2003 county payment rate for a county in the plan ($PMPM).
- RF2002 is your CY 2002 risk factor for the plan.
- RF2003 is your projected CY 2003 risk factor for the plan.
- PLA is the plan-level adjustment reflecting any modifications that M+C organizations wish to make to individual county APR calculations ($PMPM).
- CAPR2003 is the average payment rate for a county in the plan ($PMPM).
- 0.1 is the risk weight in the 90/10 risk adjustment methodology for CY 2003.
- Cn is the "nth" county in the plan's service area.

**APR for the Plan:**

$$\frac{\sum_{C1}^{Cn}(CAPR2003 \times EAM2003)}{\sum_{C1}^{Cn} EAM2003} = APR2003$$

Where:

- CAPR2003 is the average payment rate for a county in the plan ($PMPM).
- EAM2003 is the CY 2003 estimated average plan membership for a county in the plan.
- APR2003 is the average payment rate for the plan ($PMPM).
- C1 is the first county and Cn is the nth county of the plan's service area.

The following sections provide detailed instructions for completing Worksheet A1.

Note that the APR for a plan should reflect the revenue you expect to receive based on the membership you project for that plan.

The worksheet automatically copies the **Name of M+C Plan, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

## *Part I—Rate of Change in M+C Plan Risk Factors*

On the first line, enter your CY 2002 risk factor for the plan you are pricing in the ACR. If you do not have a CY 2002 risk factor for your plan, enter the numeral 1 on the first line. An entry of 1 signifies that the risk factor for your plans is the same as the risk factor for the overall Medicare population. The worksheet will prohibit entries that are less than or equal to zero in this section and will trigger a dialogue box to prompt a correction. Do not leave the cell blank.

On the second line, enter the CY 2003 risk factor for the plan you are pricing in the ACR. Do not leave the cell blank, enter zero, or enter a negative number.

The third line automatically calculates the percentage change between the CY 2002 and CY 2003 risk factors entered on the first and second lines respectively. That cell is locked; users need not make an entry. An error message and a color change from white to red indicate that one or both of the preceding lines are blank or contain a number less than or equal to zero.

## *Part II—Calculation of Plan Annual Payment Rate (APR)*

Part II displays the CY 2003 plan APR and other values automatically calculated from the data in Part III and Part IV. All the cells in Part II are locked; users need not make any entries.

The values in Part II are defined as follows:

The **Number of Counties in this Plan** is the sum of the non-blank cells in Part III, column a.

The **CY 2003 Total Estimated Membership** is the sum of the entries in Part IV, column n.

The **CY 2003 Total Estimated Monthly Payment ($PMPM)** is the sum of the estimated total payment values by county in Part IV. It is the sum of the product of the corresponding lines in column m and column n.

The **CY 2003 Estimated APR ($PMPM)** is the average of county APRs in Part III, column m, weighted by county membership.

## *Part III—Plan Service Area and Calculation of APR by County*

The following paragraphs describe each column of Part III.

**Column a—State-County Codes.** Enter the Social Security Administration (SSA) State and county codes that define the M+C service area for the M+C plan you are pricing in the ACR. The worksheets will compare the service area you report to CMS records.

Enter each code in the form of ##### (the two-digit State code followed by the three-digit county code). Please enter any leading zeros (e.g., the zero in code 01234) so that you have a correct five-digit code. You can enter up to 50 State-county codes on the spreadsheet. If your plan has more than 50 counties, contact CMS for a customized Worksheet A1.

If you enter a non-valid State-county code (e.g., too few digits, too many digits, a code not used by SSA), "N/A" will appear on the same line in several columns of the worksheet. In addition, a dialogue box will appear with an explanation of the error. You will have to click on "retry" or "cancel" to continue with the worksheet, but ultimately the worksheet will not allow the incorrect code.

If the plan service area has more than one county, do not leave any blank cells between the first and last State-county codes in column a. If you try to type a State-county code in a cell below a blank cell, an error message will appear. To eliminate the error message, click on "Retry" or "Cancel" in the dialogue box of the error message. Then, enter a valid State-county code in the cell just below the last the one that contains a state-county code.

If you enter the same State-county code twice, the first of the duplicated cells in column a will turn red to prompt you to delete the second entry.

You can use code 99999 to indicate out-of-area enrollees. When you use that code, the term "Unassigned" will appear in column b (County Name).

Please contact CMS if you are unable to enter a valid State-county code in column a.

**Column b—County Name.** The worksheet will enter the county name that corresponds to the State-county code that you enter on the same line in column a. The cells are locked; users need make no entries. Contact CMS if the county name does not appear. The county name may help users to spot errors in their State-county code entries.

"Unassigned" will appear in this column if you use code 99999.

**Column c—CY 2002 Actual Monthly Payment Rate ($PMPM).** Enter the actual monthly payment rate in CY 2002 for each county in the service area of the plan you are pricing. You can use the actual monthly payment rates recorded for 2002 in your accounting system.

Alternatively, you can use the actual monthly payment rates found in CMS's CY 2002 monthly demographic reports for your plan.

**Column d—Adjustments to Column c.** Use column d to add back items, reflected in the amount you are reporting in column c, that CMS regularly withheld from your CY 2002 payments. Examples of such items are the Information Campaign User Fee, retroactive adjustments for institutionalized enrollees, and your deposits into a stabilization fund. In addition, please use column d to make adjustments to remove any additions CMS made to the payments you are reporting, such as your monthly withdrawal from a stabilization fund. Finally, you can use column d to add back the End Stage Renal Disease (ESRD) Network Fee. Refer to the chapter on user fees for more on the ESRD Network Fee. If you do not use column d to make the adjustments discussed in this paragraph, make them in column l.

Please include, with the paper copy of your ACR, a detailed, written justification for every adjustment in column d.

**Column e**—Column e sums the corresponding lines of column c and column d. The cells are locked; users need make no entries.

**Column f—CMS's Estimated County Payment Rate for CY 2002 ($PMPM).** The worksheet will automatically enter CMS's estimated county payment rate for CY 2002 corresponding to each county in the plan service area. The cells are locked; users need make no entries.

**Column g** displays the result of dividing column e by column f. The cells are locked; users need make no entries.

**Column h—CMS's Estimated County Payment Rate for CY 2003 ($PMPM).** The worksheet will automatically enter CMS's estimated county payment rate for CY 2003 corresponding to each county in the plan service area. The cells are locked; users need make no entries.

**Column i—CY 2003 Estimated County APR before Risk Adjustments ($PMPM).** The worksheet will display the CY 2003 estimated county APR before risk adjustments, which is the product of the values on the same lines of column g and column h. The cells are locked; users need make no entries.

**Column j—% Change in Risk Factor.** The worksheet will automatically enter the percentage change in the risk factor from Part I of this worksheet. The cells are locked; users need make no entries.

**Column k—CY 2003 Estimated County APR with Risk Adjustments ($PMPM).** The worksheet will display the result after the worksheet adjusts each value in column i by 10 percent of the change in the risk factor in column j for each respective line. The cells are locked; users need make no entries.

**Column l—Plan-Level Adjustment ($PMPM).** Enter any adjustment needed to make the county APR in column k consistent with your organization's calculations. You can enter both positive and negative numeric values in column l. Even though the worksheet will permit you to enter negative entries, it will not allow you to enter a negative amount large enough to make the values negative in the corresponding line of column k.

If not made elsewhere (e.g., in column d), include in column l your adjustments to add back items that CMS withheld from the actual CY 2002 payments you reported in column c. Examples of such items are the Information Campaign User Fee and your deposits into a

stabilization fund. In addition, make adjustments in column l to subtract any payments from CMS that were included in the data you reported for 2002 and that reflect a withdrawal from amounts in a stabilization fund. In both cases, use the appropriate CY 2003 amounts for such adjustments. Note that CMS withholds the Information Campaign User Fee for only 9 months of each year.

Please include, with the paper copy of your ACR, a detailed, written justification for every adjustment in column l.

**Column m—Estimated County APR for CY 2003 ($PMPM).** The worksheet displays the sum of column k and column l for each respective line. The cells are locked; users need make no entries.

## *Part IV—Computing Medicare Deductible and Coinsurance at the County Level*

In the future, CMS may allow M+C organizations to compute ACRs using Medicare deductible and coinsurance values at the county level. Worksheet A, Part I A, line 12 has been modified in advance, so that the form will compute a weighted average deductible and coinsurance value for the plan when CMS approves such county-by-county calculations. For contract year 2003, the Medicare deductible and coinsurance amount for all counties is $101.61 for Part A/B enrollees and $75.14 for Part B-only enrollees. These amounts were published in Enclosure 1 (Final Estimate of the Increase in the National Per Capita Growth Percentages for 2003) of the CMS letter "Announcement of Calendar Year (CY) 2003 Medicare+Choice Payment Rates," dated March 1, 2002. The calculations in Worksheet A are based on the data contained in Part IV of Worksheet A1.

**Column n—CY 2003 Estimated Average Monthly Membership.** Enter the projected average membership in CY 2003 for each county in the plan's service area. You can enter any positive whole number or zero in column n. Members can be enrolled in only one M+C plan at a time; therefore, if the organization has multiple plans in a county, ensure that membership estimates for all plans in a given county are mutually exclusive. If you enter a negative value, an error message will prompt you to correct it.

**Column o—CY 2003 Estimated Total Monthly Payment ($PMPM).** The worksheet displays the product of column m and column n for each respective line. The cells are locked; users need make no entries.

**Column p—CY 2003 Medicare Deductible and Coinsurance ($PMPM).** The worksheet will automatically enter CMS's estimate of Medicare deductibles and coinsurance for CY 2003 corresponding to each county in the plan service area. For contract year 2003, the Medicare deductible and coinsurance amount for all counties is $101.61 for Part A/B enrollees and $75.14 for Part B-only enrollees. The cells are locked; users need make no entries. Worksheet A uses those values, along with the plan membership shown in Part IV of this worksheet, to compute a weighted average Medicare deductible and coinsurance amount for the plan.

# *Printing Worksheet A1*

The “Print Worksheet” and “Print Preview” buttons in the upper right-hand corner of the worksheet will help you print the worksheet. Click on the Print Worksheet button to print the worksheet. Click on the Print Preview button for a preview of the worksheet as it will be printed. Using the buttons on the worksheet will avoid printing of blank rows.

# Chapter 4. Worksheet B—Base-Period Costs and Enrollment

Worksheet B contains the base-period data that the ACR forms use for calculating the contract-year costs of individual health care components. Generally, Medicare costs for the base period should reflect the experience for the same plan you are pricing in the ACR. Worksheet D and Worksheet F import Worksheet B data for direct medical costs, administration, and additional revenues to compute trended values for 2003. When Worksheet A contains 2-year trends based on costs for the M+C organization's non-Medicare enrollees, Worksheet D and Worksheet F both apply the trends to base-period data for trended value computations.

This chapter contains both general information about Worksheet B and specific line-by-line instructions for completing the worksheet. Some M+C organizations may not have base-period costs. The chapter tells you how to handle that situation.

## *General Information*

This section covers information and concepts that apply broadly to the entries required for Worksheet B.

### Base Period Defined

The base period is the most recently ended calendar year before the ACR is submitted. For example, the base period is calendar year 2001 for ACR proposals submitted in calendar year 2002 for CY 2003. If your plan had Medicare enrollees in the base period, record on this worksheet Medicare revenue received and costs actually incurred during the base period.

> ***EXCEPTION***—As explained below in instructions for lines 20 and 21, the coordination of benefits (COB) amount you report is not necessarily actual COB collections.

### Total Costs Reflected

Worksheet B reports information reflecting the total costs for Medicare enrollees for the base period. In addition, Worksheet B costs should include all cost sharing (i.e., co-payments, coinsurance, and deductibles) charged to plan enrollees. In other words, do not reduce the costs on Worksheet B by the amount of cost sharing charged to plan enrollees (regardless of who collects the cost sharing). However, you would remove the value of benefits that are a result of private negotiations in the context of the M+C program (e.g., with employer groups) and certain Medicaid benefits (see 42 CFR 422.106 for further explanation).

### Receipts from Reinsurance and COB

Reflect receipts from reinsurance and amounts that should have been collected for COB in the Medicare data on Worksheet B. Reduce costs of direct medical care by the amount of recoveries in the form of payments from reinsurance companies. Assign the amounts from reinsurance recoveries as an offset to the costs for related health care components. In addition, reduce direct medical costs by the amounts recovered from coordination of benefits efforts. Show separately

on the lines provided any amounts that should have been collected for COB related to medical care provided to Medicare enrollees.

## Accrual Accounting and Related Considerations

The accounting system used to report base-period entries should be accrual-based (an exception to the accrual method of accounting may be approved for certain governmental organizations).

**Worksheet B should include only entries properly accrued to the base period and those entries should track to financial statements that comply with GAAP for that period.** Worksheet B also should include any corrections needed to the your financial data if the changes were made within 75 days after the end of the base period. Corrections made after the 75-day period should be reported on Worksheet D (or on Worksheet F in the case of Optional Supplemental Benefits).

The method used in your accounting system to determine the cost PMPM for Medicare enrollees must be the same method used to determine the PMPM for non-Medicare enrollees In addition, the costs allocated to each category must represent a fair distribution of costs. Include on Worksheet B only those administration costs that bear a significant relationship to the M+C plan elected by Medicare enrollees.

The same accounting methods should be used for all columns of the worksheet.

## Plans Without Trends (Plans Without Non-Medicare Enrollees)

An M+C organization without non-Medicare enrollees in the base period, the contract period, or both periods can offer an M+C plan. In such cases, M+C organizations will not have all the data needed to complete Worksheet A, Part I B, lines 1, 2, and 3. Therefore, Worksheet A cannot compute a 2-year trend and Worksheets D and F cannot compute trended values for 2003. Nevertheless, the M+C organization still should report base-period costs on Worksheet B if the plan being priced had Medicare enrollees in the base period. The M+C organization then would use budget data to compute projected values for 2003 and record them in the expected variation cells on Worksheet D and Worksheet F.

## Plans with Atypical Base Year Costs

An M+C plan could have base-period M+C costs that the sponsoring organization considers unrepresentative and therefore views the data as unsuitable for making cost projections for 2003. Your organization could take that position for many reasons, such as when a plan operated for only a short time in the base period or had relatively few enrollees then.

Nevertheless, you should report your actual costs even though you may consider your 2001 experience to lack credibility. Enter your actual costs on Worksheet B and make necessary adjustments to any trended values on Worksheet D, Worksheet F, or both. Enter such adjustments in the expected variation cells provided on Worksheet D and Worksheet F.

## Plans Without Base-Period Data

In 2003, an M+C organization might offer a plan that did not operate in the base period. Examples of these include plans starting in 2002 or 2003.

If your plan had no Medicare enrollees in the base period, leave Worksheet B blank. Record your costs for CY 2003 as expected variations on Worksheet D, Worksheet F, or both. Use your budget data to compute projected values for 2003.

For more on this issue, refer to the table at the beginning of the discussion of Worksheet A, Part I B in Chapter 4.

## Effect of Service Area Changes on Worksheet B Data

An M+C organization might prepare an ACR to renew an existing plan that will have a different service area than the plan had in the base period. In that case, Worksheet B data will be affected by the service area change. Follow the rules in the next two paragraphs that apply to your situation.

If the plan has more counties in 2003 than it had in the base period, Worksheet B should contain data just for the base-period counties that match the contract-year counties. In other words, if your plan had counties X and Y in the base period but will have counties X, Y, and Z in the contract year, include base-period data for only counties X and Y on Worksheet B. Assuming the ACR forms have 2-year trend values on Worksheet A, the trended values for data from the base-period counties will appear on Worksheet D, Worksheet F, or both. Use other data to compute projected values for 2003 for the additional county and record them in the expected variation cells on Worksheet D and Worksheet F.

If the plan for 2003 has fewer counties than it had in the base period, Worksheet B should contain data just for the contract-year counties. In other words, if your plan had counties X, Y, and Z in the base period but will have only counties X and Y in the contract year, include base-period data only for counties X and Y on Worksheet B. This is an exception to the general rule that Worksheet B should reflect all of a plan's actual base-period costs.

## No Grouping of Statutory Benefit Categories

To make the contract year ACR as accurate as possible, display Medicare enrollee revenue and costs for the base period in the column that reflects the statutory classification (i.e., Medicare-Covered Benefits, Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits) in the PBP for the contract-year plan. (For more on the previous point, see the instructions for lines 1 through 25.) This information will be used as the basis for calculating the amount CMS will allow an M+C organization to charge Medicare enrollees for an M+C plan.

## Grouping of Health Care Components

You don't need to use all health care components (lines) for your ACR. You must use the categories of Direct Medical Care, Administration, and Additional Revenue (and POS, if the plan being priced is an HMOPOS). The other categories you use will depend on your accounting system. If you group health care components, obtain CMS's concurrence on the component groupings before the ACR due date of July 1. Your accounting system must be able to produce cost figures consistent with the ACR format, as completed, in a manner that may be audited. Include with your ACR a document showing the benefits that have been grouped and the health care components to which they were assigned.

Please make the content of each health care component on Worksheet B consistent with the classification used in the PBP, unless you have approval to group health care component data on the worksheet.

> ***EXCEPTION*—**Do not group the costs of individual Optional Supplemental Benefits on Worksheet B. Displaying them separately on Worksheet B will allow the related trended values to be shown separately on Worksheet F. That in turn will allow the ACR forms to price the Optional Supplemental Benefits separately on Worksheet F by health care component, as required by CMS regulations.

## Format of Base-Period Entries

Worksheet B will allow users to make entries using up to two decimal places except for line 27, which requires whole numbers, and the cells for the begin and end dates of the base period, which require a date format. The worksheet will not allow text entries (e.g., "N/A"), nor will it allow negative entries except on COB and additional revenue lines. Error messages will prompt you to correct entries with the wrong format.

# *Line-by-Line Instructions*

The following paragraphs provide line-by-line instructions for completing Worksheet B.

## Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type**, and **Plan ID** from Worksheet A. If "select choice" or "enter data" appears in any of these cells, make the correct entry on the corresponding cell of Worksheet A.

**Begin date.** Enter the beginning date of the base period in date format (mm/dd/yyyy).

**End date.** Enter the end date of the base period in date format (mm/dd/yyyy).

## Line 1 Through Line 27

When an M+C organization offers a collection of benefits with a common theme, such as a continuation package or a visitor program, the cost of the benefits must be broken out and shown under the correct health care component (except where CMS has approved grouping, as discussed above). In any event, show the cost for each health care component under the correct statutory category or categories.

> ***EXCEPTION***—If an M+C organization includes a POS benefit in a plan, price the benefit separately and include all of the direct medical costs on line 19 (POS).

**Line 1 through Line 19.**

**Column a:** On line 1 through line 19 of column a, the worksheet will enter the sum of the amounts on corresponding lines in columns b, c, d, and e. The cells are locked; users need make no entries.

In **columns b, c, d, and e,** record the correct cost data for each type of benefit, based on whether the benefit is Medicare-Covered, an Additional Benefit, a Mandatory Supplemental Benefit, or an Optional Supplemental Benefit. For line 1 through line 18 of column b and line 1 through line 19 of columns c, d, and e, if the benefit will be offered in the contract year, enter the base-period data in the column under which the benefit would be classified (Medicare-Covered Benefits, Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits) for the contract-year plan. If the benefit will not be offered in the contract year, enter the base-period data in the column under which the benefit was classified for the base period plan, and make a corresponding adjustment in Worksheet D. The following table may help to illustrate the application of this procedure.

| Case | Statutory Benefit Category in PBP for Base Period (2001) | Statutory Benefit Category in PBP for Contract Year (2003) | Statutory Benefit Category for CY 2003 ACR Costs on Worksheet B | Adjustment on CY 2003 ACR Worksheet D |
|---|---|---|---|---|
| Benefit to be in new statutory benefit category in contract year | Optional Supplemental Benefits | Mandatory Supplemental Benefits | Mandatory Supplemental Benefits | None |
| Benefit to be in same statutory benefit category in base period and contract years | Optional Supplemental Benefits | Optional Supplemental Benefits | Optional Supplemental Benefits | None |
| Base-period benefit to be dropped in contract year | Optional Supplemental Benefits | None—not offered in CY 2003 | Optional Supplemental Benefits | Enter an amount equal to trended value but with a negative sign |
| New benefit for contract year | None—the benefit was not offered in the base period. | Optional Supplemental Benefits | Do not show costs on Worksheet B, because the benefit was not offered in the base period. | Provide your best estimate of the benefit cost. Show the cost as an Optional Supplemental Benefit. |

***NOTE***—When entering the adjustments described in the above table on Worksheet D, be sure to enter on lines 23 and 24 of that worksheet any related offsets to the costs of administration and to additional revenue.

If an Additional Benefit or a supplemental benefit is an extension of a Medicare-Covered Benefit (for example, the benefit allows more hospital days than are covered under Medicare), record the Medicare-covered amount under column b. Record the difference between the total benefit and the Medicare-covered amount, as appropriate, under Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits.

42 CFR 422.105 states that POS benefits can be offered as an Additional Benefit, a Mandatory Supplemental Benefit, or an Optional Supplemental Benefit. Accordingly, POS benefits cannot be offered as a Medicare-Covered Benefit. As a result, line 19 (POS) is blocked out under the

Medicare-covered category (column b). Line 19 relates only to POS benefits. Costs of POS benefits must be aggregated on line 19 under the appropriate columns. Furthermore, you should obtain CMS's approval for POS benefits you wish to offer before you submit an ACR with those benefits.

**Line 20 through Line 27.**

**Lines 20 and Line 21—COB.** Please note that column b, lines 20 and line 21, and columns c through d, line 21, should reflect the coordination of benefits (COB) amount that the M+C organization was entitled to collect (regardless of the actual amount collected) when Medicare was the secondary payer for a given health care benefit. The COB amount to which M+C organizations are entitled in such instances is based on actual liabilities of other insurance coverage that Medicare enrollees have. Enter COB amounts on line 20 and line 21 in the same column (column b, c, d, or e) that you used to classify the costs of the base-period benefits to which the COB payments are related.

Note that you cannot enter COB–Other in column f on line 21. Instead, you have to allocate COB–Other for Optional Supplemental Benefits to the individual entries in column e.

Example of Adjustment for Working Medicare. If you need to approximate the adjustment for working Medicare, you can use the following methodology, using actual statistics from your records.

1. Enrolled working Medicare member months: 75

2. Enrolled Medicare member months eligible for Part A: 7,500

3. Ratio of step 1 to step 2: 75 divided by 7,500 = 0.0100

4. Compute the subtotal of Medicare-Covered Benefits on lines 1–18, column b, Worksheet B. (For this example, assume the value is $354.86 PMPM.)

5. Adjustment = Ratio from step 3 times the value from step 4: (0.010 times $354.86 PMPM) = $3.55 PMPM

6. Enter the value from step 5 on line 20, column b, Worksheet B.

**Line 22** displays the total of the preceding lines in each column of the worksheet.

**Line 23 and Line 24—Administration and Additional Revenue.** Administration, line 23, and Additional Revenue, line 24, show the costs of administration actually incurred and additional revenue collected and properly accrued in accord with generally accepted accounting principles. Show base-period Medicare costs for administration and additional revenue in the same column (column b, c, d, or e) that you use to classify the costs of the base-period benefits to which those entries are related. Note that line 23 and line 24 both are blocked under the column for Optional Supplemental Benefits (column e). Therefore, include administrative costs and additional revenues in the cost of each individual Optional Supplemental Benefit. Show the base-period costs for direct medical, administration, and additional revenues for individual Optional Supplemental Benefits in your ACR backup material.

Some organizations may not be able to identify the share of the costs of administration that should be entered on line 23 columns b, c, and d and that should be allocated to individual Optional Supplemental Benefits in column e. To deal with such a situation, first determine how much of your administration cost is related directly to the package of benefits offered to the

enrollees of the M+C plan you are pricing. Then you can compute the ratio of total costs of administration to the sum of direct medical care for Medicare-Covered Benefits, Additional Benefits, Mandatory Supplemental Benefits, and Optional Supplemental Benefits (columns b, c, d, and e). Worksheet B computes a subtotal for direct medical costs for columns b, c, and d. You will have to compute the direct medical costs for Optional Supplemental Benefits on a backup schedule. Apply the ratio (percentage change) you compute to the subtotal direct medical costs shown on line 22 for columns b, c, and d. Enter those values on line 23 in the appropriate column. In addition, increase direct medical costs for each of your individual Optional Supplemental Benefits by the same percentage. Include a schedule with all your computations when you submit your ACR.

Use the procedure described in the previous paragraph if your organization cannot identify the share of additional revenue that should be entered on line 24 columns b, c, and d and that should be allocated to individual Optional Supplemental Benefits in column e.

**Line 25** displays the total of line 22 through line 24.

**Line 26 and Line 27.** Medicare entries for lines 26 and line 27 will *not* be handled as described above in the instructions for lines 1 through 24. Instead, enter Medicare data on line 26 and line 27 in the column that correctly classifies the entry for the base period (column b, c, d, or e). For example, show all amounts collected for Additional Benefits in the base year on line 26 in that column (column c) of Worksheet B.

**Line 26—Amounts collected.** Enter in columns b, c, d, and e the per-member, per-month amounts (in dollars and cents) of total revenue collected in the form of cost sharing and premiums from all Medicare enrollees electing the M+C plan (or paid on their behalf, such as from employer groups) for Medicare-Covered Benefits, Additional Benefits, Mandatory Supplemental Benefits, and Optional Supplemental Benefits, respectively. Amounts should be reported on an accrual basis and should include all sums collected from enrollees by the M+C organization and/or any provider that furnished a benefit covered by the M+C plan. Do not include on line 26 any amounts collected from CMS.

**Line 27—Enrolled member-months.** Enter in column b the total number of enrolled-member-months for the plan during the base period. One member-month is counted for each month during which a person is enrolled in the plan.

# Chapter 5. Worksheet B1—Base-Period Financial Data

Worksheet B1 provides CMS with key financial information about M+C organizations. The indicators on the worksheet will be used to measure an organization's performance and financial health over several periods and against other M+C organizations with similar characteristics (e.g., size, geographic location). The indicators alone do not necessarily signal whether an M+C organization is going to go insolvent; they simply provide a way of evaluating the organization's financial condition and performance at a point in time. This worksheet also will be used for desk review purposes.

***NOTE***—Even though you must compile Worksheet B1 data at the M+C organization level rather than at the plan level, please fill out Worksheet B1 in every Excel workbook you submit to CMS. Also, note that the worksheet will accept only numeric values in the cells requiring entries. If you make non-numeric entries, an error message will appear to prompt you to enter a numeric value.

## *Top of Form*

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type**, and **Plan ID** from Worksheet A.

**Column a—Prior Period.** The prior period is the calendar year before the beginning of the base period. The base period is the most recently ended calendar year before this ACR proposal is due. In other words, if this ACR proposal is due in 2002, the prior period is calendar year 2000. Enter the values for lines 6–17 to two decimal places.

**Column b—Base Period.** Enter the values for lines 6–17 to two decimal places.

**Column c—Change.** The change is calculated automatically and represents base-period values less prior-year values. Users need make no entries; all the cells in the column are locked.

**Column d—% Change.** The percentage change is calculated automatically; it represents the change value divided by the prior period value. Users need make no entries; all the cells in this column are locked.

## *Use of Indicators*

**Line 1—Net worth (dollars).** Net worth equals total assets minus total unsubordinated liabilities. This amount shows an organization's excess of assets over its liabilities. It indicates the value of the firm with respect to equity.

**Line 2—Total revenue (dollars).** This figure reveals how much revenue the organization generated from all of its business plus investment, interest, and aggregate (miscellaneous) income.

**Line 3—Operating revenue (dollars).** This figure reveals how much revenue the organization generated from its primary lines of business.

**Line 4—Operating profit or loss (dollars).** This value indicates the amount of money the organization has after covering its direct medical and administrative expenses for a particular period. It reveals how well the organization is covering all of its costs of operations.

**Line 5—Net profit or loss (dollars).** This value is simply the operating surplus (or deficit) after considering taxes and extraordinary costs.

**Line 6—Medical expense ratio.** This ratio reveals the percentage of the organization's premium revenue needed to meet its direct medical costs for a particular period.

**Line 7—Administrative expense ratio.** This ratio reveals the percentage of the organization's premium revenue needed to meet its administrative costs for a particular period.

**Line 8—Overall expense ratio.** This ratio reveals the percentage of the organization's premium revenue needed to meet its direct medical and administrative costs for a particular period.

**Line 9—Operating profit margin.** This ratio reveals the percentage return the organization achieved on its operations for a particular period. It measures how effectively an organization is performing with respect to its ability to cover its fixed and variable expenses. The higher the ratio, the better an organization's financial performance.

**Line 10—Overall profit margin.** This ratio reveals the percentage return the organization achieved on its operations for a particular period when taxes and any extraordinary expenses are taken into account. It measures how effectively an organization is performing with respect to its ability to cover its fixed and variable expenses, as well its tax liability. The higher the ratio, the better an organization's financial performance.

**Line 11—Debt-to-service ratio.** This ratio indicates how effectively the organization is meeting its annual principal and interest charges on its outstanding debt.

**Line 12—Current ratio.** This ratio measures an organization's ability to meet its short-term liabilities with its current base of short-term assets. The ratio is short-term assets divided by short-term liabilities. Specifically, an organization must be able to convert its short-term assets such as investments and premium receivables to cash to cover its liabilities as they come due. A thumbnail standard for a desirable current ratio is a ratio greater than 1-to-1 (meaning that an organization has short-term assets equal to or greater than short-term liabilities). However, a current ratio of less than 1-to-1 does not imply that an organization cannot meet its obligations as they come due. See line 13 below for a more extensive explanation.

**Line 13—The sum of current assets and long-term bonds divided by current liabilities.** This ratio takes into account the fact that many organizations move a good deal of their spare cash to longer-term assets, such as Treasury and blue-chip corporate bonds. Because organizations receive cash (premiums) up front, they have a period of time to invest in longer-term assets such as Treasury bonds, which generally offer a greater return than shorter-term instruments such as certificates of deposit (CDs). Therefore, many organizations move their spare cash out of the short-term investments to take advantage of the higher return.

However, this has the effect of making an organization appear—from the current ratio analysis—as if it did not have adequate resources to meet short-term obligations. Thus, as the user of the financial statements, we must recognize that these longer-term bonds are valued at the current market price and are extremely liquid. They can be converted to cash to cover short-term obligations as easily as the short-term investments and thus should be taken into consideration when measuring an organization's ability to meet short-term obligations as they come due.

**Line 14—Days of cash on hand.** This measure is the average number of days of cash an organization currently maintains on hand with respect to its current direct medical and

administrative costs. It reveals the number of days the organization is able to cover operating expenses with its current cash on hand. Specifically, this yardstick allows one to better evaluate the organization's cash management policy—which directly reflects the organization's ability to immediately meet its obligations as they come due without the need to liquidate any investments. All other things being equal, a rising ratio is considered positive (it signifies increasing liquidity).

**Line 15—Cash-to-claims-payable ratio.** This ratio indicates the organization's ability to pay off (cover) its health, medical, and accounts payable with its available cash and cash equivalents.

**Line 16—Days in premiums receivable.** This measures the amount of premium revenue (measured in terms of days) due to the organization from the members. Additionally, it measures the organization's ability to convert its receivables to cash. If the organization's figure for days in premiums receivable is getting higher (more and more days of premiums receivable), the organization may be having difficulty converting the receivables to cash and could encounter future liquidity problems.

**Line 17—Days in unpaid claims.** This ratio indicates the number of days of claims an organization owes its members. This ratio is useful for determining whether an organization is meeting its health and medical liabilities effectively and efficiently (in a timely manner). An upward trend in this figure could indicate that the organization is becoming less able to meet its obligations as they come due (that is, the organization's liquidity is decreasing).

## *Formulas for Indicators*

**Line 1—Net worth** equals total assets minus liabilities.

**Line 2—Total revenue** is self-explanatory.

**Line 3—Operating revenue** equals total revenue less revenue from investments, interest, and other miscellaneous sources, plus co-payments.

**Line 4—Operating profit or loss** equals operating revenue less the sum of direct medical costs and administrative costs.

**Line 5—Net profit** or loss equals total revenue less direct medical costs less administrative costs less taxes and extraordinary expenses.

**Line 6—Medical expense ratio** equals medical and hospital expenses divided by operating revenue.

**Line 7—Administrative expense ratio** equals administrative costs divided by operating revenue.

**Line 8—Overall expense ratio** equals direct medical costs plus administrative costs divided by operating revenue.

**Line 9—Operating profit margin** equals operating revenue minus direct medical and administrative costs, divided by operating revenue.

**Line 10—Overall profit margin** equals total revenue minus direct medical costs, administrative costs, taxes, and extraordinary expenses, all divided by total revenue.

**Line 11—Debt-to-service ratio** equals the sum total of net income, provision for income taxes, interest expense, and depreciation, divided by the sum of interest expenses and current loans and notes payable.

**Line 12—Current ratio** equals current assets divided by current liabilities.

**Line 13—The sum of current assets plus long-term bonds divided by current liabilities** is self-explanatory.

**Line 14—Days of cash on hand** is computed under the following formula: cash + short-term investments)/([total medical and hospital expenses plus total administrative expenses]/365).

**Line 15—Cash-to-claims-payable ratio** equals the sum of cash and cash equivalents, divided by claims payable.

**Line 16—Days in premiums receivable** equals premiums receivable divided by (total premium revenue [commercial, Medicare, and Medicaid] plus fee-for-service revenue, divided by 365).

**Line 17—Days in unpaid claims** equals claims payable divided by (total medical and hospital expenses, divided by 365).

# Chapter 6. Worksheet C—Premiums & Cost Sharing

Worksheet C reflects premiums and cost sharing that the M+C organization intends to charge per member, per month for the M+C plan priced by this ACR. The amounts placed on this worksheet are limited by the amounts calculated on Worksheet E for Medicare enrollees.

## *Multiple Plans Have Different Premiums and Cost Sharing*

In a given service area, you can offer multiple M+C plans, each with its own premium and cost-sharing structure. In fact, an M+C plan can have only one plan premium and cost-sharing structure. If you want to vary a plan's premium and/or its cost-sharing structure, you need to create a separate plan and submit an ACRP for it.

> ***EXCEPTION*—**If your organization segments the service area of a plan, each segment can have its own unique premium and cost sharing requirements. A segment cannot be smaller than a payment area (e.g., county, parish). Submit a separate ACRP for each segment.

## *ACR Values Needed for All Cost Sharing*

Please include a separate ACR value for every cost-sharing amount in the PBP. CMS reviewers will question any ACR that does not contain cost-sharing values per member, per month that correspond to cost sharing in the PBP. Please ensure that all ACR entries reflect the correct health care component (line) and the correct statutory benefit category (column) in a manner consistent with the PBP.

## *No Grouping of Entries on Worksheet C*

While CMS may give case-by-case approval to organizations that request approval to group costs of certain health care components (lines) on Worksheet B, organizations cannot group cost sharing in either lines or columns of this worksheet.

## *Format of Entries*

Please note the following conventions with respect to entries on Worksheet C:

- Enter premiums and the ACR value for any items of cost sharing as positive values.
- Leave cells blank to signify that the PBP has no cost sharing corresponding to the Worksheet C cell or that the plan has no premium.
- Do not enter zero, negative values, or text entries (e.g., "NA.") on the worksheet.

To ensure that cost-sharing amounts are properly recorded on Worksheet C of the ACR, please use as many decimal places as necessary for such entries. For example, do not round off a cost-sharing entry of $0.0005 to $0.00. Instead, enter $0.0005 in the appropriate cell. Even though the

worksheet will round that amount to $0.00, the actual value will be recorded in the ACR database and will be used to verify that ACRs have cost-sharing entries that correspond to PBP cost sharing. However, enter premiums in dollars and cents using only two digits after the decimal point.

## *Coordinated Care Plan Limits*

Premiums and cost sharing for the basic benefit package are limited to the ACR value of Medicare deductibles and coinsurance (as shown on Worksheet A). In addition, premiums and cost sharing charged to Medicare enrollees in such plans are limited to the ACR value of the benefit or group of benefits.

Besides the normal ACR limitations on total charges for a coordinated care M+C plan, there is an additional limit on premiums and cost sharing for Part A benefits offered to remaining Part B-only Medicare enrollees. The limit on Part B-only plan premiums and cost sharing for Part A services is discussed in the section on Worksheet C1.

## *Private Fee-for-Service Plan Limits*

The ACR form does not regulate premiums charged by an M+C PFFS plan. However, cost sharing charged to Medicare enrollees in such plans is limited to

- the ACR value of Medicare deductibles and coinsurance (as shown on Worksheet A) and
- the ACR value of the benefit or group of benefits.

## *Line-by-Line Instructions*

The following paragraphs provide detailed instructions for completing Worksheet C.

### Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

### Line 1 Through Line 19

Enter on lines 1 through 19 the cost sharing in dollars and cents per member, per month for every benefit subject to cost sharing in the PBP. Use the same line and column location in the ACR that you used for the benefit in the PBP. The PBP for any plan may have cost sharing identified in a note section as well as in individual data entry boxes. Please do not forget to include on Worksheet C the PMPM equivalents of cost sharing identified only in PBP note fields.

The PBP permits assignment of deductibles to benefits at levels ranging from plan-wide to individual health care sub-components. ACR amounts for deductibles at the various benefit levels should be handled as follows:

- Plan-Level Deductibles—Enter ACR amounts for plan-level deductibles (i.e., deductibles that apply to all benefits of a plan) on line 13ded of the worksheet. The organization should use its best estimates in allocating of the plan-level deductible amounts to the correct statutory benefit categories.

- Other Deductibles—You can aggregate ACR amounts for deductibles that apply to certain health care components and sub-components on the appropriate health component line unless your organization wishes to allocate the amounts to sub-components. Enter ACR amounts for deductibles for specific health care sub-components on the same sub-component line used in the PBP. In both cases, organizations should assign the ACR amounts to the same statutory benefit category used in the PBP. If the deductible cuts across more than one statutory benefit category, organizations should use their best judgment to allocate the deductible costs to the correct category. In the latter case, if Medicare-Covered Benefits is one of the categories, assume that those benefits are used first.

Use line 19 to record the costs of your POS benefit, if you have one. Only organizations pricing HMOPOS plans and non-M+C plans can use line 19.

Many cells in column a are grayed out. Those cells do not correspond to Medicare-Covered Benefits.

## Line 20 Through Line 27

Enter on line 20 and line 21, as appropriate, any expected revenue from enrollees for cost sharing related to benefits for which original Medicare would be the secondary payer.

**Lines 22, 23, and 24** are not used on this form.

**Line 25** computes the individual sums of column a, b, and c for lines 1 through 21. The cells for line 25 are locked.

Fill in columns a and c, line 26 to reflect the premiums expected to be charged to Medicare enrollees for basic benefits (columns a and b) and to Medicare enrollees for Mandatory Supplemental Benefits (column c).

**Line 27** computes the total charges (premiums and cost sharing) for each statutory benefit category. The cells are locked.

## Column d

**Column d** computes the sum of corresponding lines in columns a, b, and c. The cells in column d are locked.

# Chapter 7. Worksheet C1—Part B-Only Maximum Charge for Part A Benefits

Worksheet C1 is required for Part B-only plans. It is not relevant to Part A/B plans.

As stated in the discussion of Worksheet C, there is a limit on the maximum amount that can be charged (in terms of premiums and cost sharing) for certain benefits offered to remaining Part B-only Medicare enrollees. An M+C organization may choose to include benefits equivalent to Medicare benefits covered under Part A (inpatient hospital benefits, skilled nursing benefits, etc.) as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. The maximum that can be charged for the equivalent Part A benefits is the lesser of

- the ACR value of Part A benefits;
- the sum of the APR for Part A benefits, the actuarial value of Medicare's Part A deductible and coinsurance, and the ACR value of Medicare's Part A COBs; or
- the sum of the amount Medicare would charge for Part A benefits to individuals who otherwise do not qualify for Part A coverage and the actuarial value of Part A deductible and coinsurance.

Worksheet C1 is provided to calculate the limit on Part B-only plan charges for Part A services. **The amount you enter on line 12 of Worksheet C1 also must be included on Worksheet C.** As stated above, the Part A benefits offered in a Part B-only plan can be classified only as Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits. Please note that Part A benefits cannot be classified as Medicare-Covered in a Part B-only plan.

The worksheet requires you to enter four values for Part B-only plans. Those values should be entered on lines 1, 3, 5, and 12. None of the values in the four cells can be negative. (Those four cells will be locked if the enrollee type is Part A/B.) The worksheet calculates or is pre-populated with the required values for lines 4, 6, 8, 9, 10, and 11. The enrollee type at the top of the form is imported from Worksheet A. The following paragraphs provide detailed instructions for completing Worksheet C1.

## *Top of Form*

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

## *Lines 1, 3, 5, and 12*

The following paragraphs provide line-by-line instructions for completing Worksheet C1. The worksheet grays out lines 1, 3, 5, and 12 for all plans with enrollee types other than Part B-only.

**Line 1.** Enter on line 1, column b the ACR value of Part A benefits that your plan provides. If your Part B-only plan provides all Part A benefits and you have a plan of the same type in the same service area that covers Part A/B enrollees, the required ACR value is the difference between the ACRs for the two plans.

**Line 3.** Enter on line 3, column a the APR value of Part A benefits that your plan provides. If your Part B-only plan provides all Part A benefits and you have a plan of the same type in the same service area that covers Part A/B enrollees, the required APR value is the difference between the APRs for the two plans.

**Line 5.** Calculate the projected ACR value of Medicare Part A coordination of benefits for your projected working aged population. The value represents an estimate of the amount that you are entitled to collect from third-party payers (e.g., an enrollee's auto insurance company) when Medicare is the secondary payer for a given health care benefit.

**Line 12.** Enter your proposed charge to Part B-only enrollees for Part A benefits in this plan. Line 12, column b must be less than or equal to line 11. (Note that the cell on line 12, column b will turn red if that is not the case.) If you charge less than the maximum allowable, show the difference on Worksheet D, line 24ev1. Use the Additional Benefits column, the Mandatory Supplemental Benefits column, or both depending on the classification of benefits in this plan. If the plan offers both categories of benefits, allocate the amount on line 12 to both categories.

> ***REMINDER***—Include any amount on line 12 of this worksheet in the appropriate cells of Worksheet C.

# Chapter 8. Worksheet D—Expected Cost and Variation

Worksheet D serves two purposes. First, it calculates and displays the total expected costs in dollars per member, per month for each health care component under three of the four statutory benefit categories (i.e., Medicare-Covered Benefits, Additional Benefits, and Mandatory Supplemental Benefits). Second, Worksheet D is the vehicle for reflecting any expected variations from trended values of per-member, per-month costs for health care components in those three categories.

The following sections provide general instructions for and information about the worksheet.

## *Trended Values*

The worksheet computes **trended values** for individual health care components in three columns (a, c, and e), thus providing one trend computation for all of the statutory benefit categories except for Optional Supplemental Benefits. Trended values for Optional Supplemental Benefits appear on Worksheet F.

The trended value for the health care components of Medicare direct medical costs is the base-period value of the component reported on Worksheet B adjusted by the direct medical care trend from Worksheet A. The trended value for administration costs is the base-period value of administration reported on Worksheet B adjusted by the administration trend from Worksheet A. The trended value for the total is the base-period value of Medicare total costs reported on Worksheet B adjusted by the non-Medicare trend for collections from enrollees/initial rate from Worksheet A. The trended value for additional revenue is the result of subtracting the direct medical care subtotal (line 22) and administration (line 23) from the total trended value (line 25).

If organizations did not have non-Medicare enrollees in the base period and/or do not expect to have them in the contract-year, initial rates cannot be computed. In that case, there will be no entries in columns a, c, and e. Similarly, no entries will appear in those columns if the plan did not incur any Medicare costs in the base period.

## *Adjusted Values*

The **adjusted values** in columns b, d, and f, reflect the sum of any expected variations (as described below) recorded on a given line and the trended value on same line in the column on the left. For example, the adjusted value for Medicare-covered home health benefits (line 6, column b) is the trended value on the same line under column a plus the expected variation on line 6, column b that you have entered on Worksheet D.

If an organization chose to make no expected variation entries, the adjusted values would equal the trended values.

## *Expected Variations*

Expected variation entries serve several purposes. These include adjusting trended values and reporting contract year data when trended values are unavailable. This section discusses and provides guidance on the various types of expected variation entries. In addition to complying

with the guidance in this chapter, each expected variation entry also should follow all the rules for reporting data on Worksheet B. For example, make sure that expected variation entries for the components of direct medical care meet the definition of medical care in this document. Therefore, you should not reduce direct medical costs by cost-sharing amounts collected from enrollees, regardless of who collects it. Refer to Chapter 5 and the definitions in this document for more about reporting cost data on the ACR in general and on Worksheet B specifically.

## Examples of Expected Variation Entries

The expected variation cells in Worksheet D allow you to incorporate information not accounted for in the base period. For example, if CMS adds another benefit to those covered under original Medicare for the period of the ACR, the cost of the new benefit would not be reflected in the base-period costs for a given plan. Therefore, the M+C organization would make the ACR computation to approximate more closely the cost that would be incurred for the Medicare population during the ACR period.

The expected variation cells also allow you to adjust trended values because the trend Worksheet A computed is inappropriate. The trend from Worksheet A would be inappropriate, for example, if you project that your Medicare costs will change at a different rate than your non-Medicare costs.

In addition, the expected variation cells allow organizations to enter the 2003 data for any plan ACR that does not generate trended values. For example, M+C organizations offering M+C plans without non-Medicare enrollees in either or both the base period and the contract year, the trended value columns will be blank. The same is true for organizations without Medicare enrollees in the base period. As a result, such organizations must use the appropriate expected variation cell in Worksheet D (or Worksheet F for Optional Supplemental Benefits) to enter the expected contract-year cost for individual health care components. Similarly, organizations offering new benefits should use the expected variation cells to record the expected cost of those benefits for the contract year. **Document such estimates clearly and develop them using generally accepted accounting principles.**

Furthermore, use the expected variation cells in Worksheet D to delete the trended value costs for any base year benefit not offered in the contract year. Moreover, as discussed later in this section, use the expected variation entries to disaggregate (i.e., apportion) trended values as necessary.

> ***REMINDER***—Worksheet B should include only entries properly accrued to the base period, and those entries should track to financial statements for that period **that comply with GAAP**. Worksheet B should also include any corrections needed to the audited financial data if the changes were made within 75 days after the end of the base period. Report corrections made after the 75-day period on Worksheet D (or on Worksheet F in the case of Optional Supplemental Benefits).

Finally, M+C organizations should use this worksheet to adjust for any errors in the formulas built into the electronic ACR. Annotate the adjustments in a supplemental document as a "formula error," with the cell reference to identify which formula is in error.

## No Grouping of Expected Variation Entries

Expected variation entries on Worksheet D or Worksheet F must be consistent with the PBP in terms of the classification by line and column. Even though you secure approval from CMS to group data for various health care components on Worksheet B, you cannot group any related expected variations for various health care components on Worksheet D. In other words, if you are grouping data for health care components on Worksheet B, and if column c, Part I B of Worksheet A displays a trend, the trended values on Worksheet D will be grouped. Although you are not usually required to disaggregate the trended values, you must enter expected variations in the correct line and column consistent with the benefit category used in the PBP for the plan benefits.

The following example illustrates that point. Consider an M+C organization that obtains CMS approval to group costs of certain health care components on ACR Worksheet B. Assume that, in completing its ACR, the organization groups costs for preventive dental services (normally shown on line 16) together with the costs of preventive services on line 14 (Preventive Services) under the Mandatory Supplemental Benefits column. In addition, assume that Part I B of Worksheet A computes a trend so that Worksheet D shows a trended value for the health care professional component under column e (Trended Value Mandatory Supp. Benefits). Because of the grouping on Worksheet B, the trended value on Worksheet D, line 14 includes costs of both benefits. Assume further that the organization needs to adjust the trended value that relates only to mandatory supplemental preventive dental benefits. While the organization would not have to disaggregate the trended values between the two health care components mentioned above, it would have to enter the expected variation under Mandatory Supplemental Benefits on line 16 (Dental), not on line 14.

## Format of Expected Variation Entries

To ensure that expected variations are properly recorded on Worksheet D, use as many decimal places as necessary. For example, do not round off an expected value entry of $0.0005 to $0.00. Instead, enter $0.0005 in the appropriate cell. The worksheet will round (and truncate) all entries of less than 1/2 cent per member, per month to $0.00 (with the correct sign), but the actual value that you enter will be stored in the ACR database. Blank entries signify that no adjustments are necessary to the related trended value for a given statutory category. Therefore, leave cells blank if no adjustments are necessary to a particular trended value; the worksheet will not let users enter $0.00.

The worksheet will allow negative entries, however, it will not allow users to enter negative values large enough to make corresponding health care components (or related sub-components) negative on lines 1 through 19 and line 23 of the Medicare-Covered, Additional, and Mandatory Supplemental benefit categories.

The worksheet will not allow text entries (e.g., “N/A”).

## Making Expected Variation Entries

Record expected variations on the expected variation line for each health care component under the appropriate statutory benefit category. As described above, the expected variations will be added to trended values on the same line in the next column on the right (i.e., the same statutory benefit category).

## Justification of Expected Variations

Justify in writing all entries in expected variation cells in Worksheet D (except for negative entries on line 24ev2). Please submit such justifications with the paper copy of your ACR. Naturally, any justification provided should be in enough detail to fully explain the specific variation at issue. Some justifications can be very brief. For example, merely stating that an expected variation was needed to eliminate the costs in the worksheet for a previously offered benefit that is being dropped in the contract year would be adequate. Other justifications, such as ones pertaining to the costs of a new benefit and positive entries on line 24, need to be more detailed and must include all computations.

# *Line-by-Line Instructions*

This section provides detailed instructions on completing Worksheet D.

## Top of Form

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

## Line 1 Through Line 19

Enter expected variations on line 1ev through line 18ev in columns b, d, and f and on line 19ev, columns d and f.

Whenever cells on line 1 through line 19 in columns a, c, and e turn yellow, please enter the sub-component line numbers from Worksheet C for every sub-component covered by the particular expected variation entry. For example, if you enter an expected variation on line 14 (Preventive Services) of column a on this worksheet, and the variation covers both immunizations and diabetes monitoring, enter 14b and 14i, separated by a comma, in that cell.

## Line 20

Enter expected variations on line 20ev in column b.

***NOTE*—**You may want to adjust any trended value in Worksheet D for COB-Working Medicare if you used the optional methodology, discussed in Chapter 2, to develop an estimate for line 20 in Worksheet B. You should consider adjusting the trended value if you have any expected variation entries on line 1 through line 18 of this worksheet or if you project a significantly different number of enrolled working Medicare in the contract year than your plan experienced in the base period. If you decide to make an adjustment, you can use the methodology in Chapter 2 to calculate the COB value for the contract year. Subtract the contract-year value (calculated under the methodology in Chapter 2 using contract year values) from the base-period value to obtain the amount of the expected variation entry for line 20ev.

## Line 21

Enter expected variations on line 21ev in columns b, d, and f.

## Line 22 and Line 23

**Line 22** is the subtotal of the preceding lines in each column.

Enter expected variations for costs of administration on the line 23, columns b, d, and f.

## Line 24

Enter expected variations for additional revenue on the components of line 24, columns b, d, and f. Generally, those cells are used to

- make adjustments needed to correct errors on Worksheet E;
- reflect State-mandated requirements (e.g., financial requirements) that affect your M+C plan; and/or
- make the residual additional revenue values in columns a, c, and e of this worksheet more precise.

### *Correcting Error Messages on Worksheet E*

With respect to error messages, line 24ev1 provides an option you can use to make adjustments needed to eliminate errors on Worksheet E, lines 17, 21, and/or 26. You also can correct the errors on Worksheet E, lines 17, 21, and/or 26 by changing Worksheet C to modify the charges to enrollees.

Use line 24ev2 only when your adjusted ACR (Worksheet E, line 7) exceeds your APR (Worksheet E, line 1). For example, if the adjusted ACR on line 7 is greater than the APR on line 1, "ERROR" will appear on line 8. In that case, enter an adjustment on Worksheet D, column b, line 24ev2 to reduce additional revenues (thereby reducing the adjusted ACR) enough to equalize the adjusted ACR and the APR. The amount of the required adjustment is displayed in Worksheet E column b, line 8.

### *Reflecting State Mandates*

Use expected variation cells on line 24ev3 to reflect State mandates (e.g., financial requirements) affecting your plan. For example, use the line to record State-mandated transfers to reserve accounts.

### *Improving the Precision of Additional Revenue Values*

With respect to improving the precision of additional revenue values on Worksheet D, consider that a loss incurred in a prior period can produce a loss in the ACR period based on the trended value computation. However, you cannot carry forward to the contract year losses realized in the base period. Therefore, you would need to adjust additional revenue for the ACR contract year. Use line 24ev1 for such adjustments.

### *Documentation Requirements*

As indicated earlier in this chapter, justifications such as ones pertaining to positive entries on line 24 need to be detailed and must include all computations. Please explain fully your need for any increase in the trended value for additional revenues.

## Column g

**Column g** shows the adjusted value of total benefits, which is the contract-year value of all health care components including administration and additional revenue. Column g sums the values on each corresponding line of columns b, d, and f. Make no entries in column g; the cells are locked.

## Line 25

**Line 25** sums lines 22, 23, and 24 in each column.

# Chapter 9. Worksheet E—Adjusted Community Rate for the Standard Benefit Package

Worksheet E calculates the ACR for the standard benefit package for the M+C plan you are pricing. All cells are locked; no user entries are needed. The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type**, and **Plan ID** from Worksheet A.

Descriptions for other automatically calculated cells follow. Worksheet E has been programmed to provide error messages to help you resolve problems that could interfere with uploading of your ACR to HPMS or could cause CMS reviewers to question your ACR. This chapter discusses many possible errors. CMS can provide assistance to help you resolve errors not discussed in this chapter.

Unless otherwise noted, all lines relate to column a.

**Line 1** enters the APR from Worksheet A, column a, line 8.

**Line 2** enters the direct medical care costs of Medicare-Covered Benefits from Worksheet D, column b, line 49.

**Line 3** enters the administrative costs of Medicare-Covered Benefits from Worksheet D, column b, line 50.

**Line 4** enters the additional revenues related to Medicare-Covered Benefits from Worksheet D, column b, line 51.

**Line 5** sums lines 2 through 4.

**Line 6** enters the actuarial value of Medicare's deductible and coinsurance from Worksheet A, Part I A, column a, line 12. CMS regulations allow M+C organizations to compute ACRs using Medicare deductible and coinsurance values at the county level. Worksheet A, Part I A, line 12 computes a weighted average deductible and coinsurance value for the plan. The calculations in Worksheet A are based on the data contained in Part IV of Worksheet A1.

***NOTE***—The amount on line 6 includes the actuarial value of Medicare's co-payment for psychiatric benefits.

**Line 7** subtracts the amount shown on line 6 from the ACR (line 5). The amount is called the adjusted ACR.

**Line 8** subtracts the adjusted ACR (line 7) from the APR (line 1).

If the remainder is zero, you should not have any entries on line 11 and you should not have any contributions to a stabilization fund.

If the remainder is a positive value, you can use the excess amount shown on this line to fund contributions to a stabilization fund, Additional Benefits, a reduction of plan enrollees' Medicare Part B premium, a reduction of the plan premium, and a reduction of plan cost sharing. See the material on lines 9, 11, 13, 14, 15, and 17 for more on those uses. You also can request withdrawals from a sinking fund if the plan meets the conditions in 42 CFR 422.312. Another option is to make adjustments (that you can justify) on Worksheet D to increase the plan ACR, thereby reducing the excess amount. Finally, you can combine almost all of the actions described

in this paragraph. The only exception is that a plan cannot have withdrawals from and contributions to a stabilization fund during the same contract period.

**Line 8** cannot be less than zero. If line 8 displays a negative number, an error message will appear in column a in lieu of the negative number. In that case, check for errors in other worksheets. Correct any errors you find. If you do not find any other errors, you can enter an adjustment on Worksheet D, column b, line 24ev2 to reduce additional revenues enough to equalize the adjusted ACR and APR. That adjustment is needed because losses in excess of any APR cannot be charged to beneficiaries. Please do not use line 24ev2 of Worksheet D for any purpose other than to equalize the adjusted ACR and APR.

**Line 8**, column b shows the amount of any required adjustment needed in column a.

**Line 9** copies the amount to be deposited in or withdrawn from a stabilization fund from Worksheet A, Part I A, line 9. CMS will change the monthly amount it will pay to the organization per Medicare enrollee by the amount on line 9.

You will see an error message in column a if you enter a value on line 9 that exceeds 15 percent of line 8. When an error message appears, line 9, column b will calculate and display 15 percent of line 8.

**Line 10** subtracts from the excess amount (line 8) any contributions to a stabilization fund (line 9). If the amount on line is negative (i.e., reflects a withdrawal from a stabilization fund), line 10 subtracts that amount, thereby increasing the excess amount.

If line 10 is zero, you should have no entry on line 11.

If the amount on line 10 is positive, refer to the description of line 8.

Line 10 cannot be less than zero. If line 10 is less than zero, an error message will appear in the cell. If line 8 and line 10 are both less than zero, refer to the description of line 8. If line 8 is correct, you must adjust the amount on line 9, column a, Part I A of Worksheet A. Line 10, column b of this worksheet will show the amount of any required adjustment.

**Line 11** reflects the value shown on line 11 of Worksheet A, Part I A. Column a will display an error message if the value on line 11 exceeds the value on line 10. If an error message appears in column a, column b will compute and display the amount by which you must reduce line 11, column a.

**Line 12** displays the result of subtracting line 11 from line 10.

If the amount on line 12 is positive, refer to the description of line 8.

**Line 12** cannot be less than zero. If line 12 is less than zero, an error message will appear in the cell. If line 8 and line 12 are both less than zero, refer to the description of line 8. If line 8 is correct, you must adjust the amount in Worksheet A, Part I A, line 11. In that case, refer to the instructions for Worksheet A, Part I A, line 11.

***NOTE***—For plans covering Part A/B enrollees, line 12 is the hospice rate described in 42 CFR 422.266 (c).

**Line 13** enters the direct medical care costs for Additional Benefits from Worksheet D, column d, line 22.

**Line 14** enters the costs of administrative for Additional Benefits from Worksheet D, column d, line 23.

**Line 15** enters the additional revenue for Additional Benefits from Worksheet D, column d, line 24.

**Line 16** sums lines 13 through 15. Additional Benefits cannot exceed the amount on line 10. If they do, an error message will appear in the cell. Make required adjustments on Worksheet D—for example, in the appropriate column under additional revenue on line 24ev1.

**Line 17** subtracts line 16 from line 12.

If the amount on line 17 is positive, refer to the description of line 8.

**Line 18** enters the actuarial value of Medicare's deductible and coinsurance from Worksheet A, Part I A, column a, line 11. The amount is the same value displayed on line 6.

***NOTE***—The amount on line 18 includes the actuarial value of Medicare's co-payment for psychiatric benefits.

**Line 19** enters the amount from line 17. The worksheet will subtract this amount from line 18 to determine the ACR value of the amount that plan enrollees will be charged for plan premiums and cost sharing. The value on line 19 must not exceed the value shown on line 18.

**Line 20** subtracts line 19 from line 18. The remainder represents the amount that an M+C organization can charge its Medicare enrollees for Medicare-Covered Benefits and Additional Benefits (including all payments in the form of premiums, deductibles, coinsurance, and co-payments) consistent with the other entries on the ACR.

**Line 21,** column a, enters the total of all actual charges to the Medicare enrollee for Medicare-Covered Benefits and Additional Benefits. The worksheet sums the amounts found on Worksheet C, columns a and b, line 27.

If this amount does not equal the amount on line 20 above, an error message will appear in the cell. In that case, please take one or more of the following actions:

- Check for errors in base-period costs on Worksheet B, trend values on Worksheet A, and expected variation entries on Worksheet D. Make any required adjustments.
- Adjust charges (on Worksheet C) to the Medicare enrollee.
- Adjust additional revenue on Worksheet D, using line 24ev1 in column b or column d.

The amount of any required adjustment is shown on line 21, column b.

**Line 22** enters the direct medical care cost of Mandatory Supplemental Benefits from Worksheet D, column f, line 22.

**Line 23** enters the cost of administration of Mandatory Supplemental Benefits from Worksheet D, column f, line 23.

**Line 24** enters the additional revenue for Mandatory Supplemental Benefits from Worksheet D, column f, line 24.

**Line 25** sums lines 22 through 24.

**Line 26,** column a, enters the total of all actual charges to the Medicare enrollee for Mandatory Supplemental Benefits. That amount appears on Worksheet C, column c, line 27. If this amount does not equal the amount in column e, line 25, please take one or more of the following actions:

- Check for errors in base-period costs on Worksheet B, trend values on Worksheet A, and expected variation entries on Worksheet D. Make any required adjustments.
- Adjust charges (on Worksheet C) to the Medicare enrollee.
- Adjust additional revenue on Worksheet D, line 24ev1, column f.

The amount of any required adjustment is shown on line 26, column b.

**Line 27** displays the sum of line 21 and line 26. That sum represents the total amount that the M+C organization can charge its Medicare enrollees for the benefit package under the plan you are pricing.

# Chapter 10 Worksheet F—Adjusted Community Rate for Optional Supplemental Benefits

Regulations at 42 CFR 422.310(a)(3) require M+C organizations to calculate a separate ACR for each optional supplemental benefit offered under a specific M+C plan. Worksheet F calculates those ACRs with data from other ACR worksheets. You can combine individual health care components under a single premium for marketing purposes; nevertheless, you must price each health care component in a group individually on Worksheet F. Thus, the maximum charge for a group (i.e., package) of health care components would be the sum of the maximum charges for all of the components.

M+C organizations should use Optional Supplemental Benefits as a way of reducing the number of ACRPs. For example, if an M+C organization wanted to offer two plans that were identical except for the annual limit on prescription drugs, it should offer one plan (one ACRP) with an optional supplemental benefit. Therefore, if the desired prescription drug limits were $1,500 and $2,000 per year, the M+C organization's plan would have drug benefit of $1,500 as an additional benefit or mandatory supplemental benefit. The plan would also contain an optional supplemental prescription drug benefit of $500 that would provide a maximum drug benefit of $2,000.

> ***REMINDER***—Worksheet B should include only entries properly accrued to the base period, and those entries should track to financial statements for that period **that comply with GAAP**. Worksheet B should also include any corrections needed to the audited financial data if the changes were made within 75 days after the end of the base period. Corrections made after the 75-day period should be reported on Worksheet D (or Worksheet F, in the case of Optional Supplemental Benefits).

## *Top of Form*

The worksheet automatically copies the **Name of M+C Plan, Plan Type, Org. #, H#, Enrollee Type,** and **Plan ID** from Worksheet A.

## *Column a Through Column i*

**Column a—Optional Supplement Benefits.** Pick the name of a health care component from the drop-down menu on each individual line from line 1 to line 25. The drop-down menu will appear when your cursor is on any of those lines. Any single health care component can appear in more than one package of Optional Supplemental Benefits. Only organizations pricing HMOPOS plans and non-M+C plans can select POS from the drop-down menu. If you *did not* select HMOPOS or non-M+C on Worksheet A, Part I A, line 5, the cells in column a of this worksheet will turn red if you select POS.

If you plan to offer more than one individual benefit, do not leave any blank cells in column a between your first and last entries. If you do, error messages will appear. Also, if you have a

blank cell in column a and you try to enter data in other columns on that line, error messages will appear to prompt a correction.

**Column b—Package ID.** Enter an identification (ID) number to signify in which package of Optional Supplemental Benefits the benefit in column a will appear. Use 001 to identify the first package (or only package if you have just one package). Use whole numbers in sequence (e.g., 002, 003) to identify any additional packages of Optional Supplemental Benefits.

**Column c—ACR before Adjustments.** The worksheet will automatically enter an ACR value for 2003 for each individual optional supplemental benefit (health care component) in column a if data in Worksheets A and B support such a calculation. The ACR value will represent the product of the 2-year trend value from line 1 of Worksheet A, Part I B. If the ACR lacks a 2-year trend value, base year data or both for an individual benefit, column c will be blank.

**Column d—Adjustments (Expected Variation).** If the adjacent cell in column c is not blank, enter in column d any adjustment needed to make the trended value for 2003 more accurate. Explain the reason for the adjustment in your ACR backup material.

If the adjacent cell in column c is blank, enter the 2003 ACR value for the benefit. Remember to include COB–Other receipts, costs of administration, and additional revenue with the expected variation for each benefit. Please provide detailed calculations supporting your estimates in the backup material for your ACR. Be sure to break out the amounts for direct medical costs, administrative costs, and additional revenue for each benefit.

You can make negative adjustment in column d; however, you cannot enter a negative adjustment large enough to generate zero or a negative amount in the same line of column e. If you make an "oversize" negative adjustment in column d, error messages will appear in the worksheet to prompt you to correct the error.

***NOTE*—**Please refer to the chapter on Worksheet D for a general discussion of expected variation entries. As indicated in that chapter, please make sure that each expected variation entry on this form follows the rules for expected variations as explained in the chapter on Worksheet D. In addition, expected variation entries should follow the rules for reporting data on Worksheet B. For example, make sure that the direct medical costs are not reduced by the value of cost sharing paid by or on behalf of plan enrollees. Refer to the chapter on Worksheet B and the definitions in this document for more on the rules for reporting ACR data.

**Column e—ACR (Total Projected Price).** The worksheet enters the ACR (total projected price) for each individual optional supplemental benefit in column a. The ACR value is the sum of the values, if any, in column c (ACR before Adjustments) and column d (Adjustments).

The ACR for an optional supplemental benefit represents the amount you must charge (in terms of the total of cost sharing and premium) each beneficiary for that benefit. If you include that benefit in a package with other Optional Supplemental Benefits, the ACR is the benefit's share of the total package costs.

The amount shown on each line of column e should be the same as the amount on the corresponding line of column h (Total). If not, an error message will appear. In that case, check your pricing, cost sharing, and premium amounts for errors.

If the column e is zero or negative for any benefit in column a, the message "No Cost" will appear. In that case, enter cost values as appropriate or delete the benefit.

**Column f—Cost Sharing.** Enter the Medicare enrollee's cost sharing PMPM for the health care component shown in column a.

**Column g—Premiums.** Enter the Medicare enrollee's premium PMPM for the health care component shown in column a.

**Column h—Total.** The worksheet enters the sum of columns f (Cost Sharing) and g (Premiums) separately for each benefit shown in column a.

Columns e and h must display identical values. If they don't, error messages will appear in the upper right hand corner of the worksheet and in column h and column i. In the event of an error in a given row, the corresponding cell of column h will display an action you can take (e.g., "Reduce Premium") to correct the error. The action displayed, however, may be only one of the possible actions you can take to correct the error. If you make more than one error on a given row, the suggested solution will relate to the first error the system detects and will disappear only after you correct that error.

**Column i—Adjustment Needed to Fix Error.** Column i computes the dollar amount of the change you need to make to correct an error in one or more of the other columns. The value shown in each cell of column i relates to an error (or errors) in the same row. If you have made more than one apparent error, the value shown in column i will cover all errors. The value will change each time you enter a change on the corresponding row. The cell will become blank when the system no longer detects an error in the same row on the worksheet.

**Column j—Package ID.** Column j shows the package ID that corresponds to the package premium shown in the next column (column k).

**Column k—Package Premium.** Column k shows the total premiums PMPM for all packages of Optional Supplemental Benefits the plan offers.

Worksheet A, Part III, line 2 displays the sum of all the premiums PMPM for the Optional Supplemental Benefits offered by the plan. The total premium displayed on Worksheet A is mainly for purposes of the certification. The total may not be meaningful for other uses if two or more of the packages of Optional Supplemental Benefits overlap each other.

# Chapter 11. Enrollees Electing Hospice

M+C plan enrollees who elect hospice generally receive health care related to their terminal illness from the hospice, not the M+C organization. However, such enrollees may need other health care not related to their terminal illness. If an enrollee remains in an M+C plan after making a hospice election, the M+C organization (not the hospice) must provide any such other health care its plan covers.

Costs of and payments for hospice benefits for M+C enrollees who remain in an M+C plan after electing hospice are not part of an ACR. In addition, costs of and payments for Medicare-covered services (not hospice) that an M+C organization provides to such enrollees are not covered in an ACR. On the other hand, costs of and payments for non-Medicare-covered services other than hospice that M+C organizations provide to such enrollees are covered by an ACR.

The following sections provide more detail on how costs of and payments for those different types of benefits relate to the ACR.

## *Hospice Benefits*

As stated above, when an M+C plan enrollee elects hospice, the hospice provides the enrollee with the Medicare-covered hospice benefit. An M+C organization cannot bill Medicare for the costs of those benefits. Original Medicare pays the hospice directly for such costs. Therefore, neither the hospice costs nor original Medicare's reimbursement for them should be included in an ACR.

## *M+C Program Benefits*

With respect to the costs an M+C organization incurs for benefits other than those that are the responsibility of a Medicare hospice, all such costs, except for the costs of Medicare-Covered Benefits, should be reflected in an ACR. Payments by CMS or by plan enrollees for such benefits also should be reflected in an ACR.

### M+C Medicare-Covered Benefits

An M+C organization should bill (or should authorize the provider of the service to bill) fee-for-service Medicare for any Medicare-Covered Benefits an M+C plan provides to an enrollee who elects hospice, if the benefits are not "hospice" (as defined in 42 CFR 418). The base year costs for such Medicare-Covered Benefits should not be included in Worksheet B. In addition, contract-year projections of such costs should not be in Worksheet D. Finally, Medicare's reimbursement (under fee-for-service) to M+C organizations for the costs of non-hospice Medicare-Covered Benefits should not be included in the ACR.

### M+C Non-Medicare-Covered Benefits (Costs)

With respect to M+C plans that were in force two years before the contract year, report on Worksheet B costs for non-Medicare-Covered Benefits (i.e., Additional Benefits, Mandatory Supplemental Benefits, and Optional Supplemental Benefits) provided to enrollees electing hospice. Worksheets D and F will import such costs and will apply the appropriate trend factor

(from Worksheet A) to them. The relevant entries on Worksheets E and F will be affected accordingly.

If your plan did not provide Additional Benefits, Mandatory Supplemental Benefits, or Optional Supplemental Benefits in the base period to members electing hospice, you will not have any related costs to report on Worksheet B. The same is true if your plan did not operate in the base period. Therefore, if you need to project such costs in the contract year, report them as an expected variation on Worksheet D or Worksheet F, as appropriate.

## M+C Non-Medicare-Covered Benefits (Payments)

CMS payments for M+C non-Medicare-Covered Benefits for enrollees electing hospice are included in the average payment rate (APR) for a plan's ACR. Cost sharing paid by the enrollees for such benefits is included in ACR Worksheets C and F. The following sections provide more information about the effects of enrollee elections of hospice on those payments.

### *Average Payment Rate*

As described in the instructions for Worksheet A1, an M+C plan's projected membership is one of the important determinants of its APR. Generally, membership projections used for the APR should include some enrollees who have elected or may elect hospice. However, if an organization has adequate justification, it can project zero enrollees electing hospice for purposes of the APR. Please note that, as discussed below, CMS's current payment rate to an existing M+C plan is already reduced if the plan has enrollees who have elected hospice.

When any enrollee of an M+C plan elects hospice, CMS notifies the relevant M+C organization and reduces its monthly payment to the organization for that enrollee. The reduced payment, or hospice rate, is determined by the plan's ACR for that contract year. In contract year 2003, the hospice rate is the adjusted excess amount on line 12 of Worksheet E.

*Existing Plans*

The APR for an M+C plan in force during the year before the contract year is affected by any hospice payments to the M+C organization in the former (i.e., current) year. Because hospice payments are lower than CMS's regular payments to M+C organizations, whenever its previous year payments were reduced because of enrollees electing hospice, its contract-year APR always will be lower than it would have been otherwise (assuming no offsetting adjustments in columns d or l of the worksheet). Use columns d or l of Worksheet A1 to make any adjustments needed to improve APR projections because of differences between projections of enrollees electing hospice for the current year and the contract year.

*New Plans*

New plans will have no current year payments from CMS to enter on Worksheet A1. Therefore, projections of payments for enrollees projected to elect hospice in the contract year must be included in column j. The payments should be consistent with the number of projected enrollees electing hospice that is included in the plan membership estimates on Worksheet A1.

### *Cost Sharing*

Cost-sharing values in Worksheet C should reflect hospice enrollees in the plan membership.

## *Insignificant Adjustments*

M+C organizations don't have to make the adjustments described above if they can demonstrate that making them would not affect the adjusted excess amount on Worksheet E by more than 1 cent per member, per month.

# Chapter 12. Enrollees with ESRD

Generally, Medicare eligibles with end stage renal disease (ESRD) cannot enroll in an M+C plan. However, an exception applies to people with ESRD who were non-Medicare members of the managed care organization in the month preceding the month of enrollment as a Medicare member. In addition, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 permits ESRD enrollees of an M+C plan that has terminated to enroll in another M+C plan in their area. Finally, Medicare eligibles that develop ESRD while enrolled in an M+C plan can remain in the plan.

CMS has a special payment rate for ESRD enrollees. If the plan had ESRD enrollees in the year before the contract year, the ESRD payments will be included in CMS's actual payment rate for that year. With respect to the calculations on Worksheet A1, the APR will be higher than otherwise for any plan with ESRD payments in the previous year (assuming no offsetting adjustments in columns d or l of Worksheet A1).

Reflect in your Worksheet B costs any base-period costs that an M+C organization incurs for enrollees with ESRD. M+C organizations can use the expected variation feature of Worksheet D to make any necessary adjustments to trended values for the contract year.

During an on-site audit of their ACRPs, M+C organizations must be able to document the justification for projecting no ESRD enrollees in the contract year or for projecting significantly fewer ESRD enrollees in the contract year than in previous years.

***NOTE***—Medicare is the secondary payer for health care for people in the first 30 months of ESRD. Medicare becomes the primary payer in the 31st month.

M+C organizations don't have to make the adjustments described in this chapter if they can demonstrate that making them would not affect the adjusted excess amount on Worksheet E by more than 1 cent per member, per month.

# Chapter 13. User Fees

The following is a discussion of the ESRD Network Fee and the Information Campaign User Fee.

## *ESRD Network Fee*

CMS reduces the payment rate for enrollees with ESRD by the equivalent of 50 cents per renal dialysis treatment. The funds are used to help pay for the ESRD network program.

M+C organizations can charge the network fee as an administrative expense on Worksheet B. Whenever the fee is reflected in base-period costs (Worksheet B), the fee will be in a plan's contract-year ACR costs (unless the organization removes it using an expected variation entry in Worksheet D).

If you include the network fee as a cost in Worksheet D, also include it in the plan's APR. CMS's actual monthly payments used for column c of Worksheet A1 will have been reduced for withholding of the network fee. If CMS has withheld a network fee from your monthly payment, add it back by making an adjustment in columns d or l of the worksheet.

However, CMS suggests that you consider not including the ESRD Network Fee as an administrative expense in either the base period or the contract period. Thus, you would not have to adjust your APR calculations (i.e., make no adjustments in columns d or l of Worksheet A1) in the ACRP.

During an on-site audit of their ACRPs, M+C organizations should be able to document that they have made any required adjustments for the ESRD Network Fee. If they have not made the adjustments, they should be able to show that the adjustments would not materially affect the adjusted excess amount for the plan.

## *Information Campaign User Fee*

CMS assesses the Information Campaign User Fee on each M+C plan offered by M+C organizations. The purpose of the fee is to defray CMS's expenses for disseminating M+C enrollment information and operating a health insurance counseling and assistance program.

For purposes of the ACR, that fee is handled almost in the same way as the network user fee described above. The only exception relates to the fact that CMS generally withholds the information campaign fee from government payments to M+C organizations over the first 9 months of each year. Therefore, ACR preparers need to remember to average, over a 12-month interval, the total annual fee withheld. Doing so will yield the correct per-member, per-month values for Worksheet A1 or Worksheet B.

For example, some organizations use CMS's most recent monthly demographic report as the basis for APR calculations in an ACR. Typically, organizations use the demographic report for March or April, spanning the first nine months of the fiscal year. The actual monthly government payment shown in such reports will be one-ninth of the total fee, rather than one-twelfth. Therefore, you need to convert the amount to the latter basis for purposes of the ACR.

## *Insignificant Adjustments*

M+C organizations don't have to make the adjustments described in this chapter if they can demonstrate that making them would not affect the adjusted excess amount on Worksheet E by more than 1 cent per member, per month.

# Chapter 14. Waivers to Facilitate M+C Organization Contracts with Employer or Union M+C Groups

This chapter explains how CMS can facilitate M+C organization contracts with employer or union groups (having Medicare-eligible members) by waiving certain M+C rules.

## *Background*

M+C organizations can offer customized health care plans to Medicare-eligible members of employer groups and labor organizations (unions). CMS will make capitated payments to those M+C organizations to cover the costs of Medicare-eligible enrollees. The final benefit package of such plans is developed through private negotiations between an M+C organization and an employer or union. *All such plans that M+C organizations negotiate with employers and unions must cover all Medicare Part A and Part B benefits. (If the employer group has grandfathered Part B-only enrollees, it should develop a benefit package for them.) M+C organizations should not submit ACRs pricing the benefits it negotiates with employers and unions.*

Section 617 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) provides authority for CMS to waive or modify requirements that hinder the design of, the offering of, or the enrollment in M+C plans under contracts between M+C organizations and employers or unions.

The next sections discuss the waivers CMS is using under the authority BIPA granted.

## *Waiver Categories Approved*

CMS has approved four categories of waivers under the authority granted in BIPA. Two of the categories, "actuarial swapping" and "actuarial equivalence," enhance flexibility of build-ons to M+C plans designed for the individual market where the build-ons are part of an enhanced package intended for only members of an employer or union group. Another category of waiver allows an M+C organization to design a plan (i.e., an employer-only plan or union-only plan) that cannot be offered to the individual market but that can be modified to meet the needs of its contracts with employers or unions. The fourth category relates to Medicare enrollees who belong to employer or union groups and who have only Medicare Part B coverage.

### Actuarial Swapping of Benefits Not Covered by Original Medicare

M+C organizations can swap different types of benefits (not covered under original Medicare) of equal actuarial value between an M+C plan offered to the individual market and an employer or union plan. The swaps could be used if an employer prefers a different benefit package for its employees than what the M+C organization offers to the individual market. For example, when contracting with an M+C organization that includes a supplemental dental benefit in a plan offered to the individual market, an employer may prefer to offer its employees a vision benefit rather than the dental benefit. Absent an approved waiver, swapping benefits would violate the uniformity of benefits rules in Federal law.

M+C organizations do not need to obtain specific advance approval from CMS, in order to take advantage of this increased flexibility. Rather, when it submits ACRPs for the M+C plans it

intends to offer to individuals, an M+C organization must inform CMS of its intention to make actuarial swaps. In its cover letter to CMS, the organization must identify both the benefits that might be swapped during negotiations with employers and/or unions and the M+C plan covering those benefits. After CMS gives the M+C organization its general approval for the possible swaps, the organization can make specific swaps in negotiations with employers or unions, in the context of CMS's general approval, without obtaining further approval from CMS for them.

Please prepare a package documenting the calculations showing that the elements of this type of waiver are actuarially equivalent for each affected plan. The package should include a copy of the computations underlying the ACR values of affected benefits in the relevant ACR submission to CMS. (You would have included this material in the backup for your ACR submission.) In addition, please include the calculations underlying the actuarially equivalent ACR values for benefits that the employer or union has chosen for swapping. Those calculations should be consistent with the CMS instructions for ACR calculations. Retain the package in your files so that CMS auditors can review it. Do *not* include the package in your cover letter or in the ACR backup material you submit to CMS.

## Actuarial Equivalence

When negotiating with employers or unions, M+C organizations can raise cost sharing (coinsurance, co-payments, and deductibles) for certain plan benefits by providing a higher benefit level and/or a modified premium compared to what it is offering to the individual market. Generally, this category of waiver would affect prescription drug benefits. For example, assume an M+C organization offers the individual market a $500 drug benefit with $5 cost sharing per prescription. However, the M+C organization may want to be able to offer employers and/or unions an M+C plan that includes things such as an unlimited drug benefit with cost sharing of $10 per prescription, or a $500 drug benefit with $10 cost sharing and a reduced premium.

An M+C organization may take advantage of this flexibility by informing CMS of its intentions when it submits its ACRP for M+C plans it intends to offer to the individual market. In its cover letter, the M+C organizations must identify the following:

- The cost-sharing amounts it intends to increase and the M+C plan containing the cost sharing;
- Any modification to the premium it will charge; and
- Any improvement in the benefit related to the changed cost sharing.

Please prepare a package documenting the calculations showing that the elements of this type of waiver are actuarially equivalent for each affected plan. The package should include a copy of the computations underlying the ACR values of affected benefits in the relevant ACR submission to CMS. (You would have included this material in the backup for your ACR submission.) In addition, please include the calculations underlying the actuarially equivalent ACR values for benefits that the employer or union has chosen. Those calculations should be consistent with the CMS instructions for ACR calculations. Retain the package in your files so that CMS auditors can review it. Do *not* include the package in your cover letter or in the ACR backup material you submit to CMS.

CMS will allow this category of waiver without restriction to M+C organizations that need it, for purposes of a contract with an employer or union group, to modify benefits (including Medicare-

Covered Benefits) of an M+C plan offered to the individual market. (The phrase "without restriction" means the waiver can apply to either Medicare-Covered Benefits or non-Medicare-Covered Benefits.) However, M+C organizations cannot design an employer or union plan in such a way as to deny enrollees access to needed health care items and services.

## Employer-Only Plans

M+C organizations can develop an employer-only plan as the basis for developing packages offered exclusively to Medicare beneficiaries who are members of an employer or union group. Before August 2001, CMS rules permitted employers and/or unions to add benefits to an M+C plan through private negotiations, thereby making an enhanced benefit package available only to Medicare beneficiaries of that group (see 42 CFR 422.106). However, under those rules, the employer or union package was "built on" to an M+C plan, which by definition must be made available to individual Medicare beneficiaries. In contrast, this type of waiver would allow M+C organizations to develop a package that could be offered to individual employers and/or unions, but that would not be marketed or made available to the Medicare market for individuals. In addition, any such customized plans would not be disclosed in Medicare Compare.

Employer-only and union-only plans are subject to monitoring by CMS to ensure compliance with other regulatory requirements, such as appeal and grievance mechanisms.

## Part B-Only Plans

Certain Federal, State, and local employees with Medicare Part B coverage do not have Medicare Part A coverage. Medicare+Choice organizations can develop plans for Medicare beneficiaries with Part B-only coverage who are members of employer or union groups. Prepare Part B-only ACRPs in much the same way as you would prepare a Part A/B ACRP. These instructions discuss the differences between the two types of plans in the appropriate chapters. You can get other information about Part B-only plans on the Internet at http://www.hcfa.gov/pubforms/86_mmc/mc86c07.htm.

### *Service Areas*

Service areas of employer-only and union-only plans will not be restricted or linked to the service areas identified by the M+C organization for its M+C plans offered to individuals. Therefore, the service area of an employer-only plan may be larger or smaller than the service areas of the organization's M+C plans offered to individuals. However, M+C organizations must ensure that enrollees have reasonable access to providers in order to obtain medically necessary Medicare-Covered Benefits.

If the service area is larger than the currently approved service area under the M+C contract, CMS has relaxed the previous requirement for either a new plan application or a service area expansion. The service area for employer-only and union-only plans must comply with other regulatory requirements (i.e., those requirements not waived as described in this section). Medicare+Choice organizations that intend to offer a larger service area must notify their CMS central office plan manager no later than 30 days in advance of uploading their employer-only and union-only ACRP to HPMS**.** CMS must have advance notification to ensure that the new employer-only and union-only health plan counties will be included in HPMS for the plan creation process.

An entity must be an M+C organization to avail itself of these waivers. M+C organizations must be licensed by the State as a risk-bearing entity in each State in which they seek to offer an M+C plan. In addition, they must offer an M+C plan under that license. Therefore, the M+C organization must offer at least one M+C plan to individuals somewhere in the State that an employer-only or union-only plan is offered.

## ACR Filings

An ACR must be submitted for each employer-only and union-only plan being offered by the M+C organization. You can have more than one employer-only or union-only plan in a State. Submit initial ACRs at any time before the period for which the plan is being offered. Initial ACRs must cover at least 12 months. Submit renewal ACRs on July 1 of each year (or on any alternative date CMS specifies). Renewal ACRs must cover 12 months. Base-period costs in Worksheet B for an employer-only or union-only plan should reflect only employer and/or union group members' costs for Medicare-Covered Benefits and Additional Benefits. The costs in Worksheet B should reflect the employer or union group member costs for the members in the plan service area. However, if you cannot follow this rule, request an exception in your cover letter to your ACR filing for your employer-only and union-only plan.

For greater flexibility, M+C organizations have CMS permission to keep Additional Benefits to a minimum. M+C organizations can negotiate all supplemental benefits with the specific employer or union group as part of private negotiations (see 42 CFR 422.106). Follow CMS's ACR instructions when completing the remaining ACR worksheets.

M+C organizations should have a unique plan ID number for the employer-only plans. The ID number should start with the number 8 and be sequentially numbered 01 through 99. (For example, plan 1 should be 801, plan 2 should be 802, etc.)

# Chapter 15. Coordination of Benefits

The process by which one insurer (e.g., Medicare) recovers money from another insurer is called coordination of benefits (COB). When submitting ACRPs, M+C organizations are required to make estimates of potential collections (i.e., what the organization could collect) of funds under COB procedures. In the context of these instructions, COB relates to Medicare secondary payer (MSP) procedures under 42 CFR 422.108. The basic rule of MSP is that CMS does not pay for services to the extent that it is not the primary payer under section 1862(b) of the Social Security Act and 42 CFR 411.

This chapter provides background on estimates of recoveries under COB. The chapter begins with a discussion of recoveries under COB in fee-for-service (original) Medicare. Next the chapter discusses recoveries under COB in the M+C program.

## *COB in Original Medicare*

When Medicare is the only entity liable for covered health care benefits for its fee-for-service enrollees, Medicare is called the primary payer. Generally, when entities besides Medicare become liable for covered benefits, Federal law requires that Medicare become the secondary payer and that the other entity become the primary payer. (But note that when both Medicare and Medicaid are liable for a Medicare enrollee's health care, Medicare is the primary payer.) Employer-sponsored health insurance plans, workers' compensation insurance, and property and casualty insurance that cover Medicare enrollees are examples of non-Medicare entities that can become liable for Medicare enrollees' Medicare-Covered Benefits.

For example, consider a Medicare enrollee who also has health benefits under a non-Medicare property insurance policy (e.g., homeowner's insurance). Assume that the individual becomes injured in his home and receives treatment from a physician. In such a situation, the physician or injured party generally should file a claim with the carrier of the injured person's homeowners' insurance. Then, if the homeowner's insurance doesn't cover the entire claim, the physician or the patient can file a claim with Medicare for the balance. If the physician or patient inadvertently filed a claim with Medicare first, Medicare can recover all or part its costs from the enrollee's casualty insurer (depending on the limits of the insurer's liability). For instance, Medicare could recover all of its costs if the other insurer (i.e., the property insurer) were liable for 100 percent of Medicare-Covered Benefits for a Medicare beneficiary's individual claim.

Medicare enrollees for whom it is the secondary payer can be classified into two groups, depending on the type of non-Medicare health care insurance benefits to which they have access. One group is working Medicare beneficiaries, which encompasses Medicare enrollees who participate in employer-sponsored health insurance plans. Participation can result from employment of either the enrollees or their spouses. The category of working Medicare enrollees does not include all Medicare eligibles with employer-sponsored insurance. For example, Federal retirees who are eligible for Medicare and who are in the Federal Employee Health Benefits Program would be classified as working Medicare only if their non-Federal employer provided health insurance or if the retiree were covered by the spouse's non-Federal employer health insurance.

The other group consists of enrollees with access to non-Medicare health care insurance or benefits besides employer-sponsored insurance (such as the property or casualty insurance policies mentioned above). Access to the latter type of insurance might result, for example, from premiums paid by Medicare enrollees or from settlements by another person's insurance company.

# *COB in the M+C Program*

COB procedures under M+C are similar to the fee-for-service procedures described above. One important difference, however, is that M+C organizations are always primary payers for enrollees' benefits. Thus, M+C organizations have to pay for the benefits they offer even though another entity also is liable. Moreover, M+C organizations must pay for their benefits before other liable payers must pay. Nevertheless, M+C organizations have the legal right to collect and retain funds from other entities (such as casualty insurers) that also are liable for any health care benefits M+C organizations provide to enrollees of its M+C plans. (M+C organizations also can authorize their providers to collect and retain funds subject to COB procedures.) In essence, an M+C organization can recover from other entities the costs of benefits it provides to enrollees, up to the limits of the other entities' liability.

The following sections discuss how the potential and actual recoveries of funds under COB affect the ACRP process for M+C health care plans. The first section discusses the effects related to the liability of employers' health care insurance for working Medicare enrollees. The second discusses the effects related to liabilities of other entities.

## COB for Working Medicare Enrollees

Working Medicare enrollees fall into two groups:

- Those at least 65 years old (the aged) and
- Those under 65 years old, who are disabled or who have end stage renal disease.

Most M+C health care plans have some working Medicare enrollees. As stated above, all such enrollees by definition have employer-sponsored health insurance. M+C organizations (or their providers) can bill employer-sponsored health care insurance for Medicare-Covered Benefits that M+C plans provide to working Medicare enrollees.

In certain instances, the amounts that an M+C organization can collect from employer-sponsored health insurance can be established in contract negotiations between the two entities.

### *Effect on M+C Plan Cash Flow*

CMS pays M+C organizations its normal plan-specific monthly payment rate for all non-aged working Medicare enrollees. Furthermore, CMS pays M+C organizations roughly two-thirds of its normal plan-specific monthly payment rate for all aged working Medicare enrollees (i.e., excluding working Medicare eligibles under 65 years of age and people in the first 30 months of ESRD). M+C organizations can enhance this cash flow by trying to recover funds under COB from employer-sponsored health care plans, because M+C organizations can retain any amounts collected. Therefore, as long as the cost of making recoveries under COB doesn't exceed the actual recoveries, M+C organizations have an incentive to try to recover funds under COB.

### *Effect on ACR Calculations*

M+C organizations must estimate potential recoveries of funds under COB and deduct those amounts from other direct medical costs reported on an ACR. The potential recoveries are deducted from ACR costs so that the costs reflect only those for which original Medicare would be the primary payer.

### *Effect on Plan Benefits*

One of the main products of the ACR forms is the Worksheet E calculation of the "adjusted excess amount." That figure is the difference between the average payment rate (APR) and the adjusted community rate (ACR), as modified by the per-member, per-month value of Medicare deductibles and co-payments, less adjustments to any stabilization fund balance. M+C plans must offer, in addition to Medicare-Covered Benefits, Additional Benefits equal to the adjusted excess amount (both measured in terms of per-member, per-month values).

M+C organizations should report COB values on their ACRs. Reporting COB increases the adjusted excess amount. (COB receipts offset direct medical costs. Reducing direct medical costs increases the adjusted excess amount.) An increase in the adjusted excess amount would require the user to take some action in its ACR to keep it in balance. Examples of those actions are as follows:

- Increase additional benefits.
- Increase reported additional revenue.
- Reduce out-of-pocket costs.
- Increase reported cost of administration.

### *Projecting Potential Recoveries of Funds Under COB Working Medicare for ACR Purposes*

For ACR purposes, M+C organizations must make an estimate of potential recoveries of funds under COB. M+C organizations must make such estimates even if they choose not to try to recover funds under COB.

While making those projections requires some effort, most M+C organizations should have the data necessary to make reasonable ones, especially for potential recoveries from employer-sponsored heath plans. First, CMS requires M+C organizations to identify the working Medicare enrollees in their plans. Next, M+C organizations know the average costs of Medicare-Covered Benefits for all enrollees. Finally, M+C organizations may have or can obtain data on the average amounts they could recover from claims on employer-sponsored health insurance plans. The latter data would allow for the level of benefits offered by employer-sponsored insurance and/or collection problems such as legal barriers due to State laws, bankruptcy of employer-sponsored plans, or adverse court decisions. With those three elements in hand, M+C organizations can make reasonable projections of potential recoveries of funds under COB (for working Medicare enrollee benefits) to which they would be entitled.

## COB for Other Enrollees

Most M+C plans have some enrollees with workers' compensation, auto, homeowner, renter, general casualty, or other insurance policies that have health insurance benefits. If such insurers

also cover benefits that M+C organizations provide to their enrollees, the M+C organizations can bill the other entities for such benefits. M+C organizations can recover costs up to the limits of the other insurance.

COB collections related to "Other Enrollees" can enhance plan cash flow or can affect the ACR calculations and plan benefits just as COB collections related to "Working Medicare" do.

In addition, for ACR purposes M+C organizations must project potential recoveries of funds under COB from non-employer-sponsored insurance, much as they do for recoveries from employer-sponsored insurance. However, making estimates of potential recoveries under COB from other insurers may be more difficult than making projections of recoveries from employer-sponsored health care plans.

# Chapter 16. Stabilization Funds

A stabilization fund is a monetary reserve held by the Federal government on behalf of an M+C organization for the Medicare enrollees of a specific M+C plan. M+C organizations can withdraw balances in a stabilization fund to stabilize and prevent undue fluctuations in Additional Benefits of the M+C plan that originally contributed to the fund.

Amounts that an M+C organization asks CMS to withhold from government payments due on its M+C contract finance a stabilization fund. M+C organizations specify the amount of time for which the government will hold the reserved funds.

Reserved funds in a stabilization fund are uniquely identified to each participating M+C organization and, within that, to each participating M+C plan. Within each stabilization fund, CMS records annual contributions and withdrawals separately by M+C plans to account for the holding period M+C organizations specify.

## *Uses for Reserved Amounts in Stabilization Funds*

Generally, M+C organizations must use the money in a stabilization fund to provide Additional Benefits in the plan related to the fund. To the maximum extent possible, M+C organizations must use money reserved in a stabilization fund to benefit the Medicare enrollees of the M+C plan under which the funds were originally withheld.

CMS will not allow a withdrawal from the stabilization fund if the money is to be used to refinance prior contract period losses or to avoid losses in the upcoming contract period.

## *Establishing the Amount of Contributions to a Fund*

M+C organizations use ACR Worksheet A, Part I A, line 9, to tell CMS how much to withhold in a given contract period for a stabilization fund by indicating a fixed PMPM amount. CMS will withhold the amount you elect each month for the entire contract period. In other words, CMS will reduce your monthly M+C payment by the approved amount. CMS will stop withholding the approved amount at the end of a contract period. In future ACRPs, you will have the option to request that CMS withhold stabilization fund contributions for the ACRP contract period. However, you are not required to contribute to a stabilization fund and may elect not to do so.

Once CMS approves an ACR that contains a request for contributions to a stabilization fund, the M+C organization cannot change the amount to be withheld.

M+C organizations with more than one M+C plan can contribute to stabilization funds for any or all of the plans.

### Limits on Fund Contributions

CMS regulations limit the amount that you can ask CMS to withhold for any given plan in a contract period. There are two different limits. Generally, CMS will not approve requests for withholding in an ACR for a specific contract period if the requested amount would:

- Exceed 15 percent of the excess amount for that plan for that contract period (the excess amount appears on line 8 of Worksheet E) or

- Cause the total cumulative amount in the stabilization fund to exceed 25 percent of the excess amount for that plan for that contract period.

### Exceptions to the Limits on Fund Contributions

For existing plans, CMS will make an exception to the 15 percent rule if an M+C organization applying for the exception can demonstrate, using actual data, that the Additional Benefits provided to Medicare enrollees of the plan vary by more than the 15 percent limit from year to year. Federal regulations do not permit an exception to the 25 percent limit.

## *Establishing a Holding Period for Contributions*

M+C organizations use line 10 of ACR Worksheet A, Part I A to indicate how long they want CMS to hold withheld funds. The government will hold stabilization fund amounts reserved for a specific M+C plan until the M+C organization withdraws all of the reserved funds or terminates the M+C plan that established the fund, or until the holding period specified on line 10 expires, whichever comes first.

If an M+C organization terminates a plan that established a fund, or if a holding period for a fund expires, the remaining amount reserved in the stabilization fund for that plan will be forfeited to the Medicare trust funds.

## *Withdrawing Contributions*

To withdraw reserved funds, M+C organizations must give CMS advance notice in an ACRP and the conditions listed in 42 CFR 422.312(5) must be met. Briefly, these conditions are:

- The average payment rate (APR) of an M+C plan is decreasing;
- The M+C plan's ACR is significantly increasing;
- The value of Additional Benefits reported in the current ACR submission is significantly increasing over the value of Additional Benefits reported in the previous ACR submission; or
- The modified ACR (the ACR for Medicare-Covered Benefits less the actuarial value of Medicare's Deductibles and coinsurance) is increasing at a faster rate than the M+C plan's APR.

An M+C organization must notify CMS of its intent to withdraw money from its stabilization fund. In addition, M+C organizations must show the amount they wish to withdraw on line 9 of Worksheet A, Part I A, of the ACR for the plan associated with the stabilization fund.

CMS regulations generally don't force you to take any specific actions related to your reserved funds. However, if your fund-holding period or periods would expire during the contract period of the ACR you are completing and if you meet the conditions outlined above, you should consider withdrawing the reserved funds. Otherwise, the funds will be forfeited to the Medicare trust funds when the holding period expires.

**Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no one has to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0742. The time required to complete this information collection is estimated to average 95 hours per response, including the time to review instructions, to search existing data resources, to gather the data needed, and to complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 or to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.